FILED
FEB 24 2006
OFFICE OF THE CLERK
SUPREME COURT, U.S.

No. 05-200

IN THE

Supreme Court of the United States

EMPIRE HEALTHCHOICE ASSURANCE, INC.
Doing business as Empire Blue Cross Blue Shield,
Petitioner,

v.

DENISE FINN MCVEIGH, as administratrix of
the Estate of Joseph E. McVeigh,
Respondent.

On Writ of Certiorari to the
United States Court of Appeals for the Second Circuit

JOINT APPENDIX
VOLUME 2

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Petition for Certiorari Filed August 8, 2005
Certiorari Granted January 6, 2006

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FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

STANDARD CONTRACT

FOR

FEE-FOR-SERVICE CARRIERS

1996

CONTRACT FOR FEDERAL EMPLOYEES HEALTH BENEFITS

CONTRACT NO: CS 1039
EFFECTIVE: January 1, 1960

AMENDMENT NO: 1996
EFFECTIVE: 1/1/96

BETWEEN: THE UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
hereinafter called the OPM, the Agency, or the Government.

AND

CONTRACTOR: Blue Cross and Blue Shield Association Service Benefit Plan
hereinafter also called the Carrier.
Address: 1310 G Street, N.W., Suite 800
Washington, DC 20005

In consideration of payment by the Agency of subscription charges set forth in Appendix B, the Carrier agrees to perform all of the services set forth in this contract.

FOR THE CARRIER	FOR THE GOVERNMENT
Alan P. Spielman Name and Title of Signer *(Type or print)*	Lucretia F. Myers Name of Contracting Officer *(Type or print)*
Senior Vice President, Federal Programs Title of Signer	Assistant Director for Insurance Programs Title of Contracting Officer
Alan P. Spielman Signature of Person Authorized to Execute Contract	Lucretia F. Myers Signature of Contracting Officer
12/27/95 Date Signed	December 28, 1995 Date Signed

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PART II - BENEFITS

SECTION 2.1
ENROLLMENT ELIGIBILITY AND EVIDENCE OF ENROLLMENT (JAN 1998)

(a) Enrollment.

(1) Each eligible individual who wishes to be enrolled in the plan offered by this Carrier shall, as a prerequisite to such enrollment, complete a Health Benefits Registration Form within the time and under the conditions specified in the regulations. The Government personnel office having cognizance over the Enrollee shall promptly furnish notification of such registration to the Carrier.

(2) A person's eligibility for coverage, effective date of enrollment, the level of benefits (option), the effective date of termination or cancellation of a person's coverage, the date any extension of a person's coverage ceases, and any continuance of benefits beyond a period of enrollment and the date any such continuance ceases, shall all be determined in accordance with regulations or directions of OPM given pursuant to chapter 89, title 5, United States Code.

(b) Special Limitations With Regard To Employee Organizations.

(1) A plan sponsored by an employee organization as defined by the Act, is available only to eligible employees, annuitants, former spouses, and former employees and dependents (and eligible members of their families) who must be or must become members of the sponsoring organization to enroll in the Plan.

(2) Employees with membership status in an employee organization at the time they become annuitants may retain their membership in the organization and, if eligible, continue their enrollment in the Plan. Survivor annuitants of Enrollees in the Plan may continue their enrollment in the Plan without becoming members of the sponsoring employee organization.

(c) The Carrier shall issue evidence of the Enrollee's coverage and furnish to the Enrollee copies of any forms necessary to make claim for benefits.

SECTION 2.2
BENEFITS PROVIDED (JAN 1996)

(a) The Carrier shall provide the benefits as described in the Certified Brochure Text found in Appendix A.

(1) Benefits offered under this contract may be modified by the Carrier to permit methods of treatment not expressly provided for, but not prohibited by law, rule or Federal policy, if otherwise contractually appropriate, and if such treatment is medically necessary and is as cost effective as providing benefits to which the Member may otherwise be entitled.

(2) The Carrier may pay for or provide a health service or supply in an individual case which does not come within the specific benefit provisions of the contract, if the Carrier determines the benefit is within the intent of the contract, and the Carrier determines that the provision of such benefit is in the best interests of the Federal Employees Health Benefits Program.

(3) In individual cases, the Carrier (or Plan), after consultation with and concurrence by the Member and provider(s), may offer a benefit alternative not ordinarily covered under this contract which will result in equally effective medical treatment at no greater cost. The decision to offer an alternative benefit is solely the Carrier's and is not subject to OPM review under the disputed claims process.

(b) In each case when the Carrier provides a non-covered benefit in accordance with the authority of (a)(1), (2) or (3) the Carrier shall document in writing prior to the provision of such benefit the reasons and justification for its determination. Such payment or provision of services or supplies while a valid charge under the contract shall not be considered to be a precedent in the disposition of similar cases.

(c) Except as provided for in (a) above, the

Carrier shall provide benefits for services or supplies in accordance with Appendix A.

(d) The Carrier, subject to (e) below, shall determine whether in their judgment a service or supply is medically necessary or payable under this contract.

(e) The Carrier agrees to pay for or provide a health service or supply in an individual case if OPM finds that the Member is entitled thereto under the terms of the contract.

SECTION 2.3
PAYMENT OF BENEFITS AND PROVISION OF SERVICES AND SUPPLIES (JAN 1996)

(a) By enrolling or accepting services under this contract, Members are obligated to all terms, conditions, and provisions of this contract. The Carrier may request Members to complete reasonable forms or provide information which the Carrier may reasonably request; *provided,* however, that the Carrier shall not require Members to complete any form as a precondition of receiving benefits unless the form has first been approved for use by OPM. Notwithstanding Section 2.9 *Claims Processing,* forms requiring specific approval do not include claim forms and other forms necessary to receive payment of individual claims.

(b) All benefits shall be paid (with appropriate documentation of payment) within a reasonable time after receipt of reasonable proof covering the occurrence, character, and extent of the event for which the claim is made. The claimant shall furnish satisfactory evidence that all services or supplies for which expenses are claimed are covered services or supplies within the meaning of the contract.

(c) The procedures and time period for filing claims shall be as specified in the Certified Brochure Text *(Appendix A).* However, failure to file a claim within the time required shall not in itself invalidate or reduce any claim where timely filing was prevented by administrative operations of Government or legal incapacitation, provided the claim was submitted as soon as reasonably possible.

(d) The Carrier may request a Member to submit to one or more medical examinations to determine whether benefits applied for are for services and supplies necessary for the diagnosis or treatment of an illness or injury or covered condition of the Member and may withhold payment of such benefits pending completion of the examinations. The examinations shall be made at the expense of the Carrier by a physician selected by the Member from a panel of at least three physicians whose names are furnished by the Carrier, and the results of the examinations shall be made available to the Carrier and the Member.

(e) As a condition precedent to the provision of benefits hereunder, the Carrier, to the extent reasonable and necessary and consistent with Federal law, shall be entitled to obtain from any person, organization or Government agency, including the Office of Personnel Management, all information and records relating to visits or examination of, or treatment rendered or supplies furnished to, a Member as the Carrier requires in the administration of such benefits. The Carrier may obtain from any insurance company or other organization or person any information, with respect to any Member, which it has determined is reasonably necessary to:

(1) identify enrollment in a plan,

(2) verify eligibility for payment of a claim for health benefits, and

(3) carry out the provisions of the contract, such as subrogation, recovery of payments made in error, workers compensation, and coordination of benefits.

(f) Benefits are payable to the Enrollee in the Plan or his or her assignees. However, under the following circumstances different payment arrangements are allowed:

(1) Reimbursement Payments for the Enrollee. If benefits become payable to the estate of an Enrollee or an Enrollee is a minor, or an Enrollee is physically or mentally not competent to give a valid release, the Carrier may either pay such benefits directly to a hospital or other provider of services or pay such benefits to any relative by blood or connection by marriage of the Enrollee determined by the Carrier to be equitably entitled thereto.

(2) Reimbursement Payments for a minor child. If a child is covered as a family member under the Enrollee's self and family enrollment and is in the custody of a person other than the Enrollee, and if that other person certifies to the Carrier that he or she has custody of and financial responsibility for the dependent child, then the Carrier may issue an identification card for the dependent child(ren) to that person and may reimburse that person for any covered medical service or supply.

(3) Reimbursement Payments to family members covered under the Enrollee's self and family enrollment. If a covered child is legally responsible, or if a covered spouse is legally separated, and if the covered person does not reside with the Enrollee and certifies such conditions to the Carrier, then the Carrier may issue an identification card to the person and may reimburse that person for any covered medical service or supply. In the case of a legally separated spouse, the Carrier may also furnish the explanation of benefits to the spouse when determined by the Carrier to be required.

(4) Reimbursement payments to Government programs, such as Medicaid. If Federal law provides that reimbursement is payable to a Government program under coordination of benefits or similar rules, in lieu of being payable to the Enrollee or other covered person, the Carrier may reimburse the other Government program for any covered medical service or supply. To the degree that the Carrier is able to identify Medicaid beneficiaries, the Carrier will process claims directly to the provider of service or reimburse the Medicaid agency if the Medicaid agency has already paid the provider and is seeking reimbursement. When this situation is identified, the Carrier will update the member's records to ensure proper adjudication of claims.

(5) Any payments made in good faith in accordance with paragraphs (f)(1) through (f)(4) shall fully discharge the Carrier to the extent of such payment.

(g) Overpayments. If the Carrier or OPM determines that a Member's claim has been paid in error for any reason, the Carrier shall make a diligent effort to recover an overpayment to the member from the member or, if to the provider, from the provider. The Carrier shall follow general business practice and procedures in collecting debts owed under the Federal Employees Health Benefits Program. Diligent effort to recover overpayments means that upon discovering that an overpayment exists, the Carrier shall--

(1) Send a written notice of overpayment to the member or provider that provides: (A) an explanation of when and how the overpayment occurred, (B) when applicable, cite the appropriate contractual benefit provision, (C) the exact identifying information (i.e., dollar amount overpaid, date paid, check number, date of service and provider name), (D) a request for payment of the debt in full, and (E) an explanation of what may occur should the debt not be paid, including possible offset to future benefits. The notice may also offer an installment option. In addition, the Carrier shall provide the debtor with an opportunity to dispute the existence and amount of the debt before proceeding with collection activities;

(2) After confirming that the debt does exist and in the appropriate amount, send follow-up notices to the member or the provider at 30, 60 and 90 day intervals, if the debt remains unpaid and undisputed;

(3) The Carrier may off-set future benefits payable to the member or to a provider on behalf of the member to satisfy a debt due under the FEHBP if the debt remains unpaid and undisputed for 120 days after the first notice.

(4) After applying the first three steps, refer cases when it is cost effective to do so to a collection attorney or a collection agency if the debt is not recovered;

(5) Make diligent effort to recover overpayments until the debt is paid in full or determined to be uncollectible by the Carrier because it is no longer cost effective to pursue further collection efforts or it would be against equity and good conscience to continue collection efforts.

(6) Suspend recovery efforts for a debt which is based upon a claim that has been

appealed as a disputed claim under Section 2.8, until the appeal has been resolved;

(7) The Carrier may charge the contact for benefit payments made erroneously but in good faith provided that it can document that it acted with due diligence as described above.

(8) Maintain records that document individual unrecovered overpayment collection activities for audit or future reference.

(h) Overpayment recoveries may be reduced by any legal or collection agency fees expended to obtain the recoveries and which are not otherwise payable under this experience-rated contract. The amount credited to the contract shall be the net amount remaining after deducting the related legal or collection agency fees.

(i) Notwithstanding subsection (f), the Carrier reserves the right to pay the Member directly for all covered services described in the Certified Brochure Text attached as Appendix A.

SECTION 2.4
TERMINATION OF COVERAGE AND CONVERSION PRIVILEGES (JAN 1996)

(a) A Member's coverage is terminated as specified in regulations issued by the OPM. Benefits after termination of coverage are as specified in the regulations.

(b) A Member is entitled to a temporary continuation of coverage or an extension of coverage under the conditions and to the extent specified in the regulations.

(c) A Member whose coverage hereunder has terminated is entitled, upon application within the times and under the conditions specified in regulations, to a non-group contract regularly offered for the purpose of conversion from the contract or similar contracts. The conversion contract shall be in compliance with 5 U.S.C., chapter 89, and regulations issued thereunder.

(d) Costs associated with writing or providing benefits under conversion contracts shall not be an allowable cost of this contract.

(e) The Carrier shall maintain on file with OPM copies of the conversion policies offered to persons whose coverage under this contract terminates and advise OPM promptly of any changes in the policies. The Contracting Officer may waive this requirement where because of the large number of different conversion policies offered by the Carrier it would be impractical to maintain a complete up-to-date file of all policies. In this case the Carrier shall submit a representative sample of the general types of policies offered and provide copies of specific policies on demand.

SECTION 2.5
SUBROGATION (JAN 1996)

(a) The Carrier's subrogation rights, procedures and policies, including recovery rights, shall be in accordance with the provisions of the Certified Brochure Text.

(b) Subrogation recoveries may be reduced by any legal fees expended to obtain the recoveries and which are not otherwise payable under this experience-rated contract. The amount credited to the contract shall be the net amount remaining after deducting the related legal fees.

SECTION 2.6
COORDINATION OF BENEFITS (JAN 1991)
(FEHBAR 1652.204-71)

(a) The Carrier shall coordinate the payment of benefits under this contract with the payment of benefits under Medicare, other group health benefits coverages, and the payment of medical and hospital costs under no-fault or other automobile insurance that pays benefits without regard to fault.

(b) The Carrier shall not pay benefits under this contract until it has determined whether it is the primary carrier or unless permitted to do so by the Contracting Officer.

(c) In coordinating benefits between plans, the Carrier shall follow the order of precedence established by the NAIC Model Guidelines for Coordination of Benefits (COB) as specified by OPM.

(d) Where (1) the Carrier makes payments under this contract which are subject to COB

provisions; (2) the payments are erroneous, not in accordance with the terms of the contract, or in excess of the limitations applicable under this contract; and (3) the Carrier is unable to recover such COB overpayments from the Member or the providers of services or supplies, the Contracting Officer may allow such amounts to be charged to the contract; the Carrier must be prepared to demonstrate that it has made a diligent effort to recover such COB overpayments.

(e) COB savings shall be reported by experience-rated carriers each year along with the Carrier's annual accounting statement in a form specified by OPM.

(f) Changes in the order of precedence established by the NAIC Model Guidelines implemented after January 1 of any given year shall be required no earlier than the beginning of the following contract term.

[NOTE: In the event that benefits are payable to the Member under no-fault automobile insurance, the no-fault automobile insurer shall be the Primary Carrier if it is obligated legally to pay benefits for health care expenses without regard to other health benefits coverage that the Member may have. The term "no-fault automobile insurance" includes any automobile insurance policy under which the insurer pays benefits for health care expenses resulting from the accident without regard to whether the insured's conduct contributed to the accident.]

SECTION 2.7
DEBARMENT AND OTHER SANCTIONS (JAN 1996)

(a) Notwithstanding 5 U.S.C. 8902(j) or any other provision of the law and regulations, if, under 5 U.S.C. 8902a, 5 C.F.R. 970, or Public Law 103-123 (or other applicable appropriations law), a provider is barred from participating in the Program under 5 U.S.C. or the provider's services under 5 U.S.C. are excluded, the Carrier agrees that no payment shall be made by the Carrier pursuant to any contract under 5 U.S.C. (either to such provider or by reimbursement) for any service or supply furnished by such provider during the period of the debarment, except as provided in 5 C.F.R. 970.200(b).

(b) The OPM shall notify the Carrier when a provider is barred from the FEHBP.

SECTION 2.8
FILING HEALTH BENEFIT CLAIMS/COURT REVIEW OF DISPUTED CLAIMS (JAN 1996)

The processes for filing health benefit claims and for court review of disputed health benefit claims under the FEHB are as described at FEHBAR 1652.204-72.

SECTION 2.9
CLAIMS PROCESSING (JAN 1996)

A standardized claims filing process shall be used by all participating fee-for-service, individual-practice prepaid, or mixed-model prepaid FEHB carriers. Beginning in 1996, the Carrier shall develop and apply procedures for using the standard claims process. At a minimum the Carrier's program must achieve the following objectives:

(1) By the year 2000, the majority of provider claims should be submitted electronically;

(2) By January 1996, all physicians shall be notified that future claims must be submitted electronically or on the Health Care Financing Administration 1500 form;

(3) Beginning no later than June 1996, the Carrier shall not use any unique physician claim form(s) for such FEHB member claims;

(4) Beginning September 1996, Carrier should reject all such claims submitted on forms other than the HCFA 1500 form and shall explain the reason on the Explanation of Benefits form; and

(5) Carrier shall advise OPM of its progress in implementing this policy as directed by the Contracting Officer.

SECTION 2.10 CALCULATION OF COST SHARING PROVISIONS (JAN 1996)

When the Member is required to pay a specified percentage of the cost of covered services, the Member's obligation for covered services shall be based on the amount the provider has agreed to accept as full payment, including future discounts that are known and that can be accurately calculated at the time the claim is processed. This includes for example, prompt pay discounts as well as other discounts granted for various business reasons. Any discount not determined at the time of the actual adjudication shall be placed in the Special Reserve upon its determination.

PART IV -- SPECIAL PROVISIONS

SECTION 4.1
ALTERATIONS IN CONTRACT (JAN 1996)

(a) Section 1.15 Renewal and Withdrawal of Approval (FEHBAR). The following subsections are added:

(d) If the agency suspends payment of the subscription charges for any reason, the Carrier may (1) suspend making benefit payments until payment of all subscription charges due is fully restored; or (2) terminate the contract without prior notice.

(e) In the event the contract is terminated for any reason, no Member shall be entitled to benefits for services or supplies received after the last day of his or her pay period in which such termination occurs. Nor shall the Member be entitled to the conversion privilege set forth in section 2.4 after contract termination.

(b) Section 2.3 Payment of Benefits and Provision of Services and Supplies. Notwithstanding subsection (f) of section 2.3, benefits provided under the contract are not assignable by the Member to any person without express written approval of the Carrier, and in the absence of such approval, any such assignment shall be void. Notwithstanding such approval, no assignment of benefits may be made in any case prior to the time that a valid claim for benefits arises.

(c) Section 2.4 Termination of Coverage and Conversion Privileges. The conversion contract set forth in section 2.4(c) may be a contract that is regularly offered by the local Blue Cross and/or Blue Shield Plan.

(d) Section 2.5 Subrogation. The following subsections are added:

(c) To the extent that a Member has received benefits for covered services under this contract for an injury or illness caused by a third party, the Carrier shall have the right to be subrogated and succeed to any rights of recovery against any person or organization from whom the Member is legally entitled to receive all or part of those same benefits, including insurers of individual (non-group)policies of liability insurance that are issued to and in the name of the Member.

The obligation of the Carrier to recover amounts through subrogation is limited to making a reasonable effort to seek recovery of amounts to which it is entitled to recover in cases which are brought to its attention. The Carrier shall not be required to recover any amounts from any person or organization who causes an injury or illness for which a Member makes claims for benefits.

(d) The Carrier may also recover directly from the Member all amounts received by the Member by suit, settlement, or otherwise from any third party or its insurer, or the Member's insurer under an individual policy or liability insurance, for benefits which have also been paid under this contract.

(e) The Member shall take such action, furnish such information and assistance, and execute such papers as the Carrier or its representative believes are necessary to facilitate enforcement of its rights, and shall take no action which would prejudice the interests of the Carrier to subrogation.

(f) All Participating Plans shall subrogate under a single, nation-wide policy to ensure equitable and consistent treatment for all Members under this contract.

(e) Section 2.6 Coordination of Benefits (FEHBAR). The following subsections are added:

(g) In computing liability, when the Blue Cross and Blue Shield Service Benefit Plan ("this Plan") is not the Primary payer:

(1) the benefits payable by this Plan shall be determined on a claim by claim basis, except that (i) the benefits payable are limited to benefits for services and supplies set forth in the Certified Brochure Text; and (ii) the benefits payable shall be determined only for those claims in excess of $100, except in the case where the Primary payer is Medicare; and

(2) benefits shall not be payable for services and supplies that are provided beyond the day and visit limitations and the lifetime maximums set forth in the Certified Brochure Text.

(h) Whenever payments which should have been made under this contract in accordance with this provision have been made under any other group health coverage, the Carrier shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amount it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this contract and, to the extent of such payments discharged from liability under this contract.

(f) Section 3.1 Payments (FEHBAR). The following subsection is added:

(e) In the event this contract is terminated or not renewed, the agency shall be liable for all sums due and unpaid, including subscription charges, for the period up to the last day of the Member's entitlement to benefits.

(g) Section 3.2. Accounting and Allowable Cost (FEHBAR). As required by Public Law 101-508, § 8909 of title 5, U.S.C., Sections 3.2(b)(2)(ii) and 3.2(b)(2)(iv)(B) of this contract are amended by the following:

(1) No tax, fee, or other monetary payment may be imposed, directly or indirectly, on a Carrier or an underwriting or plan administration subcontractor of an approved health benefits plan by any State, the District of Columbia, or the Commonwealth of Puerto Rico, or by any political subdivision or other governmental authority thereof, with respect to any payment made from the Fund.

(2) Paragraph (1) shall not be construed to exempt any Carrier or subcontractor of an approved health benefits plan from the imposition, payment, or collection of a tax, fee, or other monetary payment on the net income or profit accruing to or realized by such Carrier or underwriting or plan administration subcontractor from business conducted under this Chapter, if that tax, fee, or payment is applicable to a broad range of business activity.

(h) Section 3.2 Accounting and Allowable Cost (FEHBAR). The provision in Section 3.2(b)(2)(iv)(A) is supplemented as follows:

Charges for mandatory statutory reserves (Section 3.2(b)(2)(iv)(A)) to satisfy mandatory statutory reserve requirements of Participating Plans are allowable to the extent that such requirements exceed that portion of the service charge at Appendix B, Subscription Rates, Charges, Allowances and Limitations applicable to such Plans.

(i) Section 3.2 Accounting and Allowable Cost (FEHBAR). The note at the end of this section is modified as follows:

[NOTE: As required by subsection (a)(1) of this section, the Carrier, not later than 120 days after the end of the contract period, shall furnish OPM for that period an accounting of its operations under the contract.]

(j) Section 3.3 Special Reserve. The provision in Section 3.3(a) is supplemented as follows:

The Special Reserve held by or on behalf of the Carrier is to be used only for

payment of charges against this contract, including advance payments to Participating Plans and to hospitals.

(k) PART V - REQUIRED CLAUSES Sections 5.30, 5.31, 5.32. Cost Accounting Standards, part 30 of the FAR, has not yet been implemented for the FEHBP. Sections 5.30, 5.31 and 5.32 are not applicable to this contract.

SECTION 4.2
HOSPITAL (FACILITY) BENEFIT PAYMENTS AND CONDITIONS (JAN 1991)

(a) Benefits described in the Certified Brochure Text shall be provided to the extent practicable in the form of services rendered by hospitals, freestanding ambulatory facilities, and home health care agencies, and payment, therefore, by or on behalf of the Carrier shall constitute a complete discharge of their obligations under this contract to the extent of services rendered in accordance with the terms and conditions of the contract.

(b) Benefits for inpatient hospital care shall be available only to a Member admitted to the hospital on the recommendation, and while under the active medical supervision of a duly licensed physician or alternative provider as described in section 8902(k)(1) of title 5 U.S.C. who is a member of the staff of, or acceptable to, the hospital selected.

(c) Hospital service is subject to all the rules and regulations of the hospital selected including rules governing admissions.

(d) While a Member may elect to be hospitalized in any hospital, the Carrier does not undertake to guarantee the admission of such Member to the hospital, nor the availability of any accommodations or services therein requested by the Member or his physician.

SECTION 4.3
DEFINITION OF CARRIER (JAN 1991)

The Carrier is the Blue Cross and Blue Shield Association, an Illinois not-for-profit corporation, acting on behalf of participating Blue Cross and Blue Shield Plans and pursuant to authority specified in Exhibit A for and in behalf of the organizations specified in Exhibit A (hereinafter sometimes referred to as "Participating Plans").

SECTION 4.4
AUDIT DISPUTES (JAN 1991)

A claim seeking, as a matter of right, the payment of money, in a sum certain, pursuant to 48 CFR section 52.233-1, shall not be made more than five years following the last day prescribed by the contract for filing the Annual Accounting Statement for the year with respect to which the claim arises. A claim includes, in the case of the Carrier, a charge to the contract.

SECTION 4.5
ASSOCIATION DUES (JAN 1996)

A Participating local Blue Cross and Blue Shield Plan may charge to this contract 90 percent of the Association dues which the Plan otherwise would charge to the contract.

SECTION 4.6
TRAVEL COSTS (JAN 1996)

The Carrier may charge and account for travel expenses related to administration of the contract on a per diem basis, subject to the maximums prescribed by the Federal Travel Regulations. For those travel costs for each contract term that are subject to the Federal per diem rates set forth at 48 CFR section 31.205-46, the Carrier shall charge to the contract an amount equal to the lesser of:

(i) the actual aggregate charges for those costs, or
(ii) the aggregate charges calculated using the per diem rates set forth in the Federal Travel Regulations.

CONTRACT FOR FEDERAL EMPLOYEES HEALTH BENEFITS

CONTRACT NO: CS 1039
EFFECTIVE: January 1, 1960

AMENDMENT NO: 1997
EFFECTIVE: 01/01/97

BETWEEN: THE UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
hereinafter called the OPM, the Agency, or the Government

AND

CONTRACTOR: Blue Cross and Blue Shield Association Service Benefit Plan
hereinafter also called the Carrier.
Address: 1310 G Street, N.W., Suite 900
Washington, DC 20005

In consideration of payment by the Agency of subscription charges set forth in Appendix B, the Carrier agrees to perform all of the services set forth in this contract.

FOR THE CARRIER	FOR THE GOVERNMENT
Alan P. Spielman	Lucretia F. Myers
Name of Signer *(Type or print)*	Name of Contracting Officer *(Type or print)*
Senior Vice President Federal Programs	Assistant Director for Insurance Programs
Title of Signer	Title of Contracting Officer
Alan P. Spielman	Lucretia F. Myers
Signature of Person Authorized to Execute Contract	Signature of Contracting Officer
12/20/96	December 20, 1996
Date Signed	Date Signed

1. All references to the 1996 contract year are changed to 1997.

2. The Table of Contents is amended, as follows:

5.14 UTILIZATION OF SMALL, SMALL DISADVANTAGED AND WOMEN-OWNED SMALL BUSINESS CONCERNS

5.31 DISCLOSURE AND CONSISTENCY OF COST ACCOUNTING STANDARDS
5.32 ADMINISTRATION OF COST ACCOUNTING STANDARDS

5.50 DEFAULT (FIXED-PRICE SUPPLY AND SERVICE)

5.55 EMPLOYMENT REPORTS ON SPECIAL DISABLED VETERANS AND VETERANS OF THE VIETNAM ERA
5.56 AUTHORIZATION AND CONSENT
5.57 NOTICE AND ASSISTANCE REGARDING PATENT AND COPYRIGHT INFRINGEMENT
5.58 MANDATORY INFORMATION FOR ELECTRONIC FUNDS TRANSFER PAYMENT
5.59 CERTIFICATION OF NONSEGREGATED FACILITIES

PART VI – APPENDICES

A- BROCHURE TEXT

3. Section 1.1, DEFINITIONS OF FEHB TERMS, is amended to JAN 1997 and amended by adding the following:

Subcontractor: Any supplier, distributor, vendor, or firm that furnishes supplies or services to or for a prime contractor, except for providers of direct medical services or supplies pursuant to the Carrier's health benefits plan.

(FFS)

Letter of Credit: The method by which certain Carriers, and their underwriters if authorized, receive recurring premium payments by drawing against a commitment (certified by a responsible OPM official) which specifies a dollar amount available. For each Carrier participating in the Letter of Credit arrangement for payment under this part, the terms "carrier reserves" and "special reserves" include any balance in the Carrier's Letter of Credit account.

4. Section 1.9, FEHB QUALITY ASSURANCE, is amended to JAN 1997 and amended as follows:

(a)

• • •

(6) Assessing Quality of Health Care. The Carrier agrees to collect data on the condition-specific patient outcomes endorsed by the Foundation for Accountability (FAcct) as requested by the OPM for services rendered through the Carrier's Preferred Provider Organization and/or Point of Service networks, and provide statistical reports, in accordance with FAcct guidelines when the data is reasonably available. For Contract Year 1997, the Carrier may be asked to collect data on one or more, but no more than three, outcomes on a pilot basis either in a specified geographic locality or nationwide. Depending on the experience during Contract Year 1997, such data collection may be expanded in future contract years.

(b) The Carrier shall conduct a program to assess its vulnerability to fraud and shall operate a system designed to detect fraud internally by Carrier employees and subcontractors, by providers providing goods or services to FEHB Members, and by individual FEHB Members.

(c) The Carrier shall keep complete records of its quality assurance procedures and fraud program and the results of their implementation and make them available to the Government as determined by OPM. If the Carrier cannot separate FEHB claims from all other claims, the Carrier may report compliance based on all claims and indicate this on the report.

(d) The Contracting Officer may order the correction of a deficiency in the Carrier's quality assurance program or fraud program. The Carrier shall take the necessary action promptly to implement the Contracting Officer's order. If the Contracting Officer orders a modification of the Carrier's quality assurance program or fraud program pursuant to this paragraph (d) after the contract year has begun, the costs incurred to correct the deficiency may be excluded from the administrative expenses -- for that contract year -- that are subject to the administrative expenses limitation specified at Appendix B; *provided* the Carrier demonstrates that the correction of the deficiency significantly increases the Carrier's liability under this contract.

5. Section 1.13, INFORMATION AND MARKETING MATERIALS, is amended to JAN 1997 and amended as follows:

(a) OPM and the Carrier shall agree upon language setting forth the benefits, exclusions and other language of the Plan. OPM, in its sole discretion, may order the Carrier to print and distribute the agreed-upon brochure text, in a format and quantity approved by OPM. This formatted document is referred to as the FEHB brochure. The Carrier shall distribute the FEHB brochure to all Federal employees, annuitants, former spouses and former employees and dependents enrolled in the Plan. The Carrier shall also distribute the document(s) to Federal agencies to be made available to such individuals who are eligible to enroll under this contract. The Carrier may print additional FEHB brochures for distribution or its own use, but only in the approved format and at its own expense.

(b) Supplemental material. Only marketing materials or other supplemental literature prepared in accordance with FEHBAR 1652.203-70 (Section 1.14 of this contract) may be distributed or displayed at or through Federal facilities.

(c) The Carrier shall reflect the statement of benefits in the agreed-upon brochure text included at Appendix A of this contract, verbatim, in the FEHB brochure.

(d) OPM may order the Carrier to prepare an addendum or reissue the FEHB brochure or any piece(s) of supplemental marketing material at no expense to the Government if it does not conform to the agreed-upon brochure text and/or supplemental marketing materials preparations described in paragraphs (a), (b) and (c) of this section.

6. The word "subcontract" in Section 1.16, SUBCONTRACTS, subparagraph (b)(3) is amended to read "subcontractor".

7. Section 2.5, SUBROGATION, is amended to JAN 1997 and paragraph (a) is amended, as follows:

(a) The Carrier's subrogation rights, procedures and policies, including recovery rights, shall be in accordance with the provisions of the agreed-upon brochure text.

8. Section 2.8, FILING HEALTH BENEFIT CLAIMS/COURT REVIEW OF DISPUTED CLAIMS, is amended to MAR 1995, the citation (FEHBAR 1652.204-72) added to the heading and the section is amended,

as follows:

(a) General. (1) The Carrier resolves claims filed under the Plan. All health benefit claims must be submitted initially to the Carrier. If the Carrier denies a claim, (or a portion of a claim), the covered individual may ask the Carrier to reconsider its denial. If the Carrier affirms its denial or fails to respond as required by paragraph (b) of this clause, the covered individual may ask OPM to review the claim. A covered individual must exhaust both the Carrier and OPM review processes specified in this clause before seeking judicial review of the denied claim.

(2) This clause applies to covered individuals and to other individuals or entities who are acting on the behalf of a covered individual and who have the covered individual's specific written consent to pursue payment of the disputed claim.

(b) Time limits for reconsidering a claim. (1) The covered individual has 6 months from the date of the notice to the covered individual that a claim (or a portion of a claim) was denied by the Carrier in which to submit a written request for reconsideration to the Carrier. The time limit for requesting reconsideration may be extended when the covered individual shows that he or she was prevented by circumstances beyond his or her control from making the request within the time limit.

(2) The Carrier has 30 days after the date of receipt of a timely-filed request for reconsideration to:

(i) Affirm the denial in writing to the covered individual;

(ii) Pay the bill or provide the service; or

(iii) Request from the covered individual or provider additional information needed to make a decision on the claim. The Carrier must simultaneously notify the covered individual of the information requested if it requests additional information from a provider. The Carrier has 30 days after the date the information is received to affirm the denial in writing to the covered individual or pay the bill or provide the service. The Carrier must make its decision based on the evidence it has if the covered individual or provider does not respond within 60 days after the date of the Carrier's notice requesting additional information. The Carrier must then send written notice to the covered individual of its decision on the claim. The covered individual may request OPM review as provided in paragraph (b)(3) of this clause if the Carrier fails to act within the time limit set forth in this paragraph.

(3) The covered individual may write to OPM and request that OPM review the Carrier's decision if the Carrier either affirms its denial of a claim or fails to respond to a covered individual's written request for reconsideration within the time limit set forth in paragraph (b)(2) of this clause. The covered individual must submit the request for OPM review within the time limit specified in paragraph (e)(1) of this clause.

(4) The Carrier may extend the time limit for a covered individual's submission of additional information to the Carrier when the covered individual shows he or she was not notified of the time limit or was prevented by circumstances beyond his or her control from submitting the additional information.

(c) Information required to process requests for reconsideration. (1) The covered individual must put the request to the Carrier to reconsider a claim in writing and give the reasons, in terms of applicable brochure provisions, that the denied claim should have been approved.

(2) If the Carrier needs additional information from the covered individual to

make a decision, it must:

(i) Specifically identify the information needed;

(ii) State the reason the information is required to make a decision on the claim;

(iii) Specify the time limit (60 days after the date of the Carrier's request) for submitting the information; and

(iv) State the consequences of failure to respond within the time limit specified, as set out in paragraph (b)(2) of this section.

(d) Carrier determinations. The Carrier must provide written notice to the covered individual of its determination. If the Carrier affirms the initial denial, the notice must inform the covered individual of:

(1) The specific and detailed reasons for the denial;

(2) The covered individual's right to request a review by OPM; and

(3) The requirement that requests for OPM review must be received within 90 days after the date of the Carrier's denial notice and include a copy of the denial notice as well as documents to support the covered individual's position.

(e) OPM review. (1) If the covered individual seeks further review of the denied claim, the covered individual must make a request to OPM to review the Carrier's decision. Such a request to OPM must be made:

(i) Within 90 days after the date of the Carrier's notice to the covered individual that the denial was affirmed; or

(ii) If the Carrier fails to respond to the covered individual as provided in paragraph (b)(2) of this clause, within 120 days after the date of the covered individual's timely request for reconsideration by the Carrier; or

(iii) Within 120 days after the date the Carrier requests additional information from the covered individual, or the date the covered individual is notified that the Carrier is requesting additional information from a provider. OPM may extend the time limit for a covered individual's request for OPM review when the covered individual shows he or she was not notified of the time limit or was prevented by circumstances beyond his or her control from submitting the request for OPM review within the time limit.

(2) In reviewing a claim denied by the Carrier, OPM may

(i) Request that the covered individual submit additional information;

(ii) Obtain an advisory opinion from an independent physician;

(iii) Obtain any other information as may in its judgment be required to make a determination; or

(iv) Make its decision based solely on the information the covered individual provided with his or her request for review.

(3) When OPM requests information from the Carrier, the Carrier must release the information within 30 days after the date of OPM's written request unless a different time limit is specified by OPM in its request.

(4) Within 90 days after receipt of the request for review, OPM will either:

(i) Give a written notice of its decision to the covered individual and the Carrier; or

(ii) Notify the individual of the status of the review. If OPM does not receive requested evidence within 15 days after expiration of the applicable time limit in paragraph (e)(3) of this clause, OPM may make its decision based solely on information available to it at that time and give a written notice of its decision to the covered individual and to the Carrier.

(f) OPM, upon its own motion, may reopen its review if it receives

evidence that was unavailable at the time of its original decision.

(g) Court review. (1) A suit to compel enrollment under § 890.102 of Title 5, Code of Federal Regulations, must be brought against the employing office that made the enrollment decision.

(2) A suit to review the legality of OPM's regulations under this part must be brought against the Office of Personnel Management.

(3) Federal Employees Health Benefits (FEHB) carriers resolve FEHB claims under authority of Federal statute (chapter 89, title 5, United States Code). A covered individual may seek judicial review of OPM's final action on the denial of a health benefits claim. A legal action to review final action by OPM involving such denial of health benefits must be brought against OPM and not against the Carrier or the Carrier's subcontractors. The recovery in such a suit shall be limited to a court order directing OPM to require the Carrier to pay the amount of benefits in dispute.

(4) An action under paragraph (3) of this clause to recover on a claim for health benefits:

(i) May not be brought prior to exhaustion of the administrative remedies provided in paragraphs (a) through (f) of this clause;

(ii) May not be brought later than December 31 of the 3rd year after the year in which the care or service was provided; and

(iii) Will be limited to the record that was before OPM when it rendered its decision affirming the Carrier's denial of benefits.

9. Section 3.1, PAYMENTS, is amended to MAY 1992.

10. Section 4.1, ALTERATIONS IN CONTRACT, is amended as follows:

Section 4.1 is amended to APR 1984 and the following phrase is added after the heading:

Portions of this contract are altered as follows:

Section 4.1 - replace existing 4.1(d)(f) with new 4.1(d)(f) to read:

(f) Effective January 1, 1997, all participating plans shall subrogate under a single, nation-wide policy to ensure equitable and consistent treatment for all Members under this contract.

11. Section 4.8 - replace existing 4.8 with new 4.8 to read:

SECTION 4.8
PRESCRIPTION DRUG BENEFITS WAIVER PROVISIONS (JAN 1997)

(a) For the purposes of applying the special provisions in this Section, the Mail Service Prescription Drug Program service standards are:

(1) When a prescription order is placed by phone or facsimile, the prescription order shall be processed within two business days so the enrollee may expect to receive the medication within 7 calendar days.

(2) When a prescription order is placed by mail, the prescription order shall be processed within five business days from the date of receipt so the enrollee may expect to receive the medication within 14 calendar days.

(b) The special provisions described in paragraphs (c)(1), (2), and (3) shall become effective automatically when less than 96 percent of the prescriptions are filled within the service standards described in either paragraph (a)(1) or (a)(2) for 7 consecutive business days. The special provisions shall terminate when for 7 consecutive business days 96

percent or more of the prescriptions are filled within the service standards described in paragraphs (a)(1) and (a)(2) of this section.

(c) The special provisions are:

(1) The Carrier shall waive during the effective periods in paragraph (b) the deductible and coinsurance for a 21 day prescription filled at a Preferred Retail pharmacy when the Mail Service Prescription Drug Program vendor is unable to fill the prescription within the service standards. This waiver of the deductible and coinsurance shall be in effect for 14 calendar days after notice to the enrollee as described in paragraph (c)(2) below. Use of the waiver will not reduce the total annual deductible required in the brochure text at Appendix A.

(2) The Carrier shall provide the enrollee a written or telephone notice no later than 2 business days prior to the end of the service standard timeframes stated in (a)(1) and (a)(2). This notice shall:

(i) advise the enrollee that the Mail Order Prescription Drug Program may not be able to fill the prescription(s) within the service standard timeframes;

(ii) advise the enrollee that any applicable deductible and coinsurance will be waived for a 21 day supply of the medication(s) when filled at a Preferred Retail pharmacy;

(iii) provide the enrollee with instructions on how to use the waiver; and

(iv) advise the enrollee when the waiver will expire.

(3) The Carrier may use next day delivery service at no additional cost to the enrollee in order to meet the service standards in (a)(1) and (a)(2).

12. Section 4.9 - replace existing 4.9 with new 4.9 to read:

SECTION 4.9

(FFS)

52.219-9 (As amended) SMALL, SMALL DISADVANTAGED AND WOMEN-OWNED SMALL BUSINESS PILOT SUBCONTRACTING PLAN (JAN 1997)

(a) This clause does not apply to small business concerns.

(b) "Subcontract," as used in this clause, means any agreement (other than one involving an employer-employee relationship) entered into by the Carrier or its subcontractor calling for supplies or services required for performance of the contract or subcontract, except for agreements with providers of direct medical services or supplies pursuant to the Carrier's health benefits plan.

(c) The Carrier, upon request by the Contracting Officer, shall submit and negotiate a subcontracting plan which separately addresses subcontracting with small business concerns, with small disadvantaged business concerns and with women-owned small business concerns. The subcontracting plan shall be included in and made a part of the resultant contract. The plan shall be negotiated within the time specified by the Contracting Officer.

(d) The Carrier's subcontracting plan shall include the following:

(1) Goals, expressed in terms of percentages of total planned subcontracting dollars, for the use of small business concerns, small disadvantaged business concerns and women-owned small business concerns as subcontractors. The Carrier shall include all subcontracts that contribute to contract performance, and may include a proportionate share of products and services that are normally allocated as indirect costs.

(2) A statement of–

(i) Total dollars planned to be subcontracted;

(ii) Total dollars planned to be subcontracted to small business

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

STANDARD CONTRACT

FOR

FEE-FOR-SERVICE CARRIERS

1998

1998 Amendments
Fee For Service Contracts

1. All references to the 1997 contract year are changed to 1998.

2. On the first page of the contract, the contractor's signature lines have been revised to make it clear that the signer is the person authorized to execute the contract. Superfluous language on the page is deleted.

3. The Table of Contents is amended to incorporate technical and editorial changes, to add new clauses, to delete obsolete FAR clauses, and to replace five (5) FAR clauses with FEHB-specific clauses, as follows:

1.20 CERTIFICATION UNDER P.L. 104-191 (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996)

2.11 BENEFITS PAYMENTS WHEN MEDICARE IS PRIMARY

5.29 TAXES--FOREIGN NEGOTIATED BENEFITS CONTRACTS

5.34 INTEREST (FEHBAR MODIFICATION OF FAR)

5.38 CHANGES--NEGOTIATED BENEFITS CONTRACTS

5.40 GOVERNMENT PROPERTY (NEGOTIATED BENEFITS CONTRACTS)

5.46 (RESERVED)

5.49 FEHBP TERMINATION FOR CONVENIENCE OF THE GOVERNMENT--NEGOTIATED BENEFITS CONTRACTS

5.50 FEHBP TERMINATION FOR DEFAULT--NEGOTIATED BENEFITS CONTRACTS

5.60 SUBCONTRACTS FOR COMMERCIAL ITEMS AND COMMERCIAL COMPONENTS

Appendix D-a. JANUARY 1998
Appendix E. JANUARY 1996
Appendix F. JANUARY 1998

4. In Section 1.1, DEFINITIONS OF FEHB TERMS, is redated JAN 1998 and the definitions of "Subcontractor" and "Letter of Credit" are amended to conform to the definitions in the Federal Employees Health Benefits Acquisition Regulation (FEHBAR), as follows:

Subcontractor: Any supplier, distributor, vendor, or firm that furnishes supplies or services to or for a prime contractor, or another subcontractor, except for providers of direct medical services or supplies pursuant to the Carrier's health benefits plan.

Letter of Credit: The method by which certain Carriers, and their underwriters if authorized, receive recurring premium payments and contingency reserve payments by drawing against a commitment (certified by a responsible OPM official) which specifies a dollar amount available. For each Carrier participating in the Letter of Credit arrangement for payment under FEHBAR 1632.170(b), the terms "carrier reserves" and "special reserves" include any balance in the Carrier's Letter of Credit account.

5. Section 1.4, INCORPORATION OF LAWS AND REGULATIONS, is redated JAN 1998 and the reference to the FAR clause has been replaced with an FEHB-specific clause reference in the contract, as follows:

(b) If the Regulations are changed in a manner which would increase the Carrier's liability under this contract, the change will be made effective for the contract period subsequent to the period in which the change is promulgated and, if the change is promulgated in November or December, the change will not be effective until the second contract year following the year in which the change is promulgated; unless (i) The Carrier agrees to an earlier date or (ii) the change is ordered by the Contracting Officer pursuant to the *Changes--Negotiated Benefits Contracts* clause of the contract.

6. Section 1.5, RECORDS AND INFORMATION TO BE FURNISHED BY OPM, is redated JAN 1998 and amended to reflect new procedures for enrollment reconciliation, as follows:

8. PART IV –SPECIAL PROVISIONS is deleted and replaced with the following:

PART IV–SPECIAL PROVISIONS

SECTION 4.1
ALTERATIONS IN CONTRACT (JAN 1999)
(FAR 52.252-4)

Portions of this contract are altered as follows:

(a) Section 1.15 Renewal and Withdrawal of Approval (FEHBAR). The following subsections are added:

(d) If the agency suspends payment of the subscription charges for any reason, the Carrier may (1) suspend making benefit payments until payment of all subscription charges due is fully restored; or (2) terminate the contract without prior notice.

(b) Section 1.21 Patient Bill of Rights. For the purpose of compliance with this Section, the Carrier will conduct the following minimum activities: (1) the Carrier will provide subscribers with a Fact Sheet that includes information about the disenrollment rate in the Blue Cross and Blue Shield Service Benefit Plan, as well as Local Plan-specific information including compliance with Federal and State financial requirements, public corporate information, years in existence, and accreditation status; (2) Provider Directories will include language advising subscribers to contact their providers directly to obtain information about the providers, including but not limited to board certifications, languages spoken, availability of interpreters, facility accessibility, and whether the provider is accepting new patients.

(c) Section 2.2 Benefits Provided. The following paragraph is added to subsection 2.2(a):

(4) The Carrier may pay the Preferred Provider Organization level of benefits under this contract to ease the hardship of members affected by natural disasters such as earthquakes, floods, etc., when because of the natural disaster members have difficulty gaining access to Preferred network providers. The Carrier may pay the Preferred level of benefits without regard to the provider's contractual relationship with the Carrier and will determine an appropriate time frame based on local conditions during which the provision of this paragraph will apply. Benefits provided under this paragraph will be made available to all members similarly affected by the natural disaster.

(d) Section 2.3 Payment of Benefits and Provision of Services and Supplies. Notwithstanding subsection (f) of Section 2.3, benefits provided under the contract are not assignable by the Member to any person without express written approval of the carrier, and in the absence of such approval, any such assignment shall be void. Notwithstanding such approval, no assignment of benefits may be made in any case prior to the time that a valid claim for benefits arises.

(e) Section 2.3 Payment of Benefits and Provision of Services and Supplies. Subsection (g)(7)(ii) of Section 2.3 is amended to read as follows: Notwithstanding (g)(7)(ii), the Carrier may not charge the contract for the administrative costs to correct erroneous benefit payments (or to correct processes or procedures that caused erroneous benefit payments) when the errors are egregious and repeated. These costs are deemed to be unreasonable and unallowable under Section 2.3(b). The term "repeated" in the previous sentence does not apply to situations in which a claims processing system error causes multiple erroneous payments or to situations that involve audit findings on errors that are endemic to the provision of insurance and claims processing.

(f) Section 2.4 Termination of Coverage and Conversion Privileges. The conversion contract set forth in Section 2.4(c) may be a

contract that is regularly offered by the local Blue Cross and/or Blue Shield Plan.

(g) Section 2.5 Subrogation. The following subsections are added:

(c) To the extent that a Member has received benefits for covered services under this contract for an injury or illness caused by a third party, the Carrier shall have the right to be subrogated and succeed to any rights of recovery against any person or organization from whom the Member is legally entitled to receive all or part of those same benefits, including insurers of individual (non-group) policies of liability insurance that are issued to and in the name of the Member.

The obligation of the Carrier to recover amounts through subrogation is limited to making a reasonable effort to seek recovery of amounts to which it is entitled to recover in cases which are brought to its attention. The Carrier shall not be required to recover any amounts from any person or organization who causes an injury or illness for which the Member makes claims for benefits.

(d) The Carrier may also recover directly from the Member all amounts received by the Member by suit, settlement, or otherwise from any third party or its insurer, or the Member's insurer under an individual policy or liability insurance, for benefits which have also been paid under this contract.

(e) The Member shall take such action, furnish such information and assistance, and execute such papers as the Carrier or its representative believes are necessary to facilitate enforcement of its rights, and shall take no action which would prejudice the interests of the Carrier to subrogation.

(f) Effective January 1, 1997, all Participating Plans shall subrogate under a single, nation-wide policy to ensure equitable and consistent treatment for all Members under the contract.

(h) Section 2.6 Coordination of Benefits (FEHBAR). The following subsections are added:

(g) The benefits payable by this Plan shall be determined, on a claim by claim basis, only for those claims in excess of $100, except where Medicare is the primary payer of benefits.

(h) Whenever payments which should have been made under this contract in accordance with this provision have been made under any other group health coverage, the Carrier shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amount it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this contract and, to the extent of such payments discharged from liability under the contract.

(i) Section 3.1 Payments (FEHBAR). The following sentence is added to the end of Section 3.1(a):
OPM will withhold from the subscription charges amounts for other obligations due under the contract only to the extent that OPM and the Carrier have agreed in writing to specific deductions for such other obligations.

(j) Section 3.1 Payments (FEHBAR). The following subsection is added:

(g) Except as required pursuant to Sections 1.25 and 2.12, in the event this contract is terminated or not renewed, the agency shall be liable for all sums due and unpaid, including subscription charges, for the period up to the last day of the Member's entitlement to benefits.

(k) Section 3.2 Accounting and Allowable Cost (FEHBAR). As required by Public Law 101-508, § 8909 of title 5, U.S.C., and Section 3.2(b)(2)(ii) of this contract are amended by the following:

(1) No tax, fee, or other monetary payment may be imposed, directly or indirectly, on a Carrier or an underwriting or

plan administration subcontractor of an approved health benefits plan by any State, the District of Columbia, or the Commonwealth of Puerto Rico, or by any political subdivision or other governmental authority thereof, with respect to any payment made from the Fund.

(2) Paragraph (1) shall not be construed to exempt any Carrier or subcontractor of an approved health benefits plan from the imposition, payment, or collection of a tax, fee, or other monetary payment on the net income or profit accruing to or realized by such Carrier or underwriting or plan administration subcontractor from business conducted under this Chapter, if that tax, fee, or payment is applicable to a broad range of business activity.

(l) Section 3.2 Accounting and Allowable Cost (FEHBAR). The provision in Section 3.2(b)(2)(iv)(A) is supplemented as follows: Charges for mandatory statutory reserves (Section 3.2(b)(2)(iv)(A)) to satisfy mandatory statutory reserve requirements of Participating Plans are allowable to the extent that such requirements exceed that portion of the service charge at Appendix B, Subscription Rates, Charges, Allowances and Limitations applicable to such Plans.

(m) Section 3.2 Accounting and Allowable Cost (FEHBAR). This section is modified as follows:
The Carrier, as required by the Blue Cross and Blue Shield Service Benefit Plan Workplan, shall furnish OPM an accounting of its operations under the contract not less than 120 days after the end of the calendar year contract period.

(n) Section 3.3 Special Reserve. The provision in Section 3.3(a) is supplemented as follows:

The Special reserve held by or on behalf of the Carrier is to be used only for payment of charges against this contract, including advance payments to Participating Plans and to hospitals.

(o) Sections 5.30, 5.31, and 5.32. The Cost Accounting Standards, Chapter 1, Part 30 and Chapter 99 of the FAR, do not apply to the FEHB Program for this contract year, except to the extent compliance with specific standards is required by the cost principles in FAR Chapter 1, Subpart 31.2 and FEHBAR Subpart 1631.2.

(p) Section 3.10, Audit, Financial, and Other Information. Compliance by the Carrier and Participating Blue Cross and Blue Shield Plans with the Blue Cross Blue Shield Service Benefit Plan Workplan, as agreed upon between the Carrier and OPM, will constitute compliance with the Audit Guide referred to in Sections 3.2 and 3.10.

SECTION 4.2
HOSPITAL (FACILITY) BENEFIT PAYMENTS AND CONDITIONS (JAN 1991)

(a) Benefits described in the agreed upon brochure text shall be provided to the extent practicable in the form of services rendered by hospitals, freestanding ambulatory facilities, and home health care agencies, and payment, therefore, by or on behalf of the carrier shall constitute a complete discharge of their obligations under this contract to the extent of services rendered in accordance with the terms and conditions of the contract.

(b) Benefits for inpatient hospital care shall be available only to a Member admitted to the hospital on the recommendation, and while under the active medical supervision of a duly licensed physician or alternative provider as described in section 8902(k)(1) if title 5 U.S.C. who is a member of the staff of, or acceptable to, the hospital selected.

(c) Hospital service is subject to all the rules and regulations of the hospital selected including rules governing admissions.

(d) While a Member may elect to be hospitalized in any hospital, the Carrier does not undertake to guarantee the admission of such Member to the hospital, nor the availability of any accommodations or services therein requested by the Member or his physician.

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

STANDARD CONTRACT

FOR

FEE-FOR-SERVICE CARRIERS

2002

BEST AVAILABLE COPY

CONTRACT FOR FEDERAL EMPLOYEES HEALTH BENEFITS

CONTRACT NO: CS 1039 AMENDMENT NO: 2002
EFFECTIVE: January 1, 1960 EFFECTIVE: January 1, 2002

BETWEEN: THE UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
hereinafter called the OPM, the Agency, or the Government

AND

CONTRACTOR: Blue Cross and Blue Shield Association
hereinafter also called the Carrier

Address: 1310 G Street, NW., Suite 900
Washington, DC 20005

In consideration of payment by the Agency of subscription charges set forth in Appendix B, the Carrier agrees to perform all of the services set forth in this contract, including Appendix A.

FOR THE CARRIER	FOR THE GOVERNMENT
Stephen W. Gammarino	Abby L. Block
Name of Person Authorized to Execute Contract *(Type or print)*	Name of Contracting Officer *(Type or print)*
Senior Vice President, FEP/IHR	Assistant Director for Insurance Programs
Title	Title
Signature	Signature
12/18/01	12/31/01
Date Signed	Date Signed

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PART II - BENEFITS

SECTION 2.1
ENROLLMENT ELIGIBILITY AND EVIDENCE OF ENROLLMENT (JAN 1999)

(a) Enrollment.

(1) Each eligible individual who wishes to be enrolled in the plan offered by this Carrier shall, as a prerequisite to such enrollment, complete a Health Benefits Election Form, or use an electronic or telephonic method approved by OPM, within the time and under the conditions specified in 5 CFR Part 890. The Government personnel office having cognizance over the Enrollee shall promptly furnish notification of such election to the Carrier.

(2) A person's eligibility for coverage, effective date of enrollment, the level of benefits (option), the effective date of termination or cancellation of a person's coverage, the date any extension of a person's coverage ceases, and any continuance of benefits beyond a period of enrollment and the date any such continuance ceases, shall all be determined in accordance with regulations or directions of OPM given pursuant to chapter 89, title 5, United States Code.

(b) Special Limitations With Regard To Employee Organizations.

(1) A plan sponsored by an employee organization as defined by the Act, is available only to eligible employees, annuitants, former spouses, and former employees and dependents (and eligible members of their families) who must be or must become members of the sponsoring organization to enroll in the Plan.

(2) Employees with membership status in an employee organization at the time they become annuitants may retain their membership in the organization and, if eligible, continue their enrollment in the Plan. Survivor annuitants of Enrollees in the Plan may continue their enrollment in the Plan without becoming members of the sponsoring employee organization.

(c) The Carrier shall issue evidence of the Enrollee's coverage and furnish to the Enrollee copies of any forms necessary to make claim for benefits.

SECTION 2.2
BENEFITS PROVIDED (JAN 1999)

(a) The Carrier shall provide the benefits as described in the agreed upon brochure text found in Appendix A.

(1) Benefits offered under this contract may be modified by the Carrier to permit methods of treatment not expressly provided for, but not prohibited by law, rule or Federal policy, if otherwise contractually appropriate, and if such treatment is medically necessary and is as cost effective as providing benefits to which the Member may otherwise be entitled.

(2) The Carrier may pay for or provide a health service or supply in an individual case which does not come within the specific benefit provisions of the contract, if the Carrier determines the benefit is within the intent of the contract, and the Carrier determines that the provision of such benefit is in the best interests of the Federal Employees Health Benefits Program.

(3) In individual cases, the Carrier, after consultation with and concurrence by the Member and provider(s), may offer a benefit alternative not ordinarily covered under this contract which will result in equally effective medical treatment at no greater cost. The decision to offer an alternative benefit is solely the Carrier's and is not subject to OPM review under the disputed claims process.

(b) In each case when the Carrier provides a non-covered benefit in accordance with the authority of (a)(1), (2) or (3) the Carrier shall document in writing prior to the provision of

such benefit the reasons and justification for its determination. Such payment or provision of services or supplies while a valid charge under the contract shall not be considered to be a precedent in the disposition of similar cases.

(c) Except as provided for in (a) above, the Carrier shall provide benefits for services or supplies in accordance with Appendix A.

(d) The Carrier, subject to (e) below, shall determine whether in its judgment a service or supply is medically necessary or payable under this contract.

(e) The Carrier agrees to pay for or provide a health service or supply in an individual case if OPM finds that the Member is entitled thereto under the terms of the contract.

SECTION 2.3
PAYMENT OF BENEFITS AND PROVISION OF SERVICES AND SUPPLIES (JAN 1999)

(a) By enrolling or accepting services under this contract, Members are obligated to all terms, conditions, and provisions of this contract. The Carrier may request Members to complete reasonable forms or provide information *provided* which the Carrier may reasonably request, however, that the Carrier shall not require Members to complete any form as a precondition of receiving benefits unless the form has first been approved for use by OPM. Notwithstanding Section 2.9, *Claims Processing*, forms requiring specific approval do not include claim forms and other forms necessary to receive payment of individual claims.

(b) All benefits shall be paid (with appropriate documentation of payment) within a reasonable time after receipt of reasonable proof covering the occurrence, character, and extent of the event for which the claim is made. The claimant shall furnish satisfactory evidence that all services or supplies for which expenses are claimed are covered services or supplies within the meaning of the contract.

(c) The procedures and time period for filing claims shall be as specified in the agreed upon brochure text (*Appendix A*). However, failure to file a claim within the time required shall not in itself invalidate or reduce any claim where timely filing was prevented by administrative operations of Government or legal incapacitation, provided the claim was submitted as soon as reasonably possible.

(d) The Carrier may request a Member to submit to one or more medical examinations to determine whether benefits applied for are for services and supplies necessary for the diagnosis or treatment of an illness or injury or covered condition of the Member and may withhold payment of such benefits pending completion of the examinations. The examinations shall be made at the expense of the Carrier by a physician selected by the Member from a panel of at least three physicians whose names are furnished by the Carrier, and the results of the examinations shall be made available to the Carrier and the Member.

(e) As a condition precedent to the provision of benefits hereunder, the Carrier, to the extent reasonable and necessary and consistent with Federal law, shall be entitled to obtain from any person, organization or Government agency, including the Office of Personnel Management, all information and records relating to visits or examination of, or treatment rendered or supplies furnished to, a Member as the Carrier requires in the administration of such benefits. The Carrier may obtain from any insurance company or other organization or person any information, with respect to any Member, which it has determined is reasonably necessary to:

(1) identify enrollment in a plan,

(2) verify eligibility for payment of a claim for health benefits, and

(3) carry out the provisions of the contract, such as subrogation, recovery of payments made in error, workers compensation, and coordination of benefits.

(f) Benefits are payable to the Enrollee in the Plan or his or her assignees. However, under the following circumstances different payment arrangements are allowed:

(1) Reimbursement Payments for the Enrollee. If benefits become payable to the estate of an Enrollee or an Enrollee is a minor, or an Enrollee is physically or mentally not competent to give a valid release, the Carrier may either pay such benefits directly to a hospital or other provider of services or pay such benefits to any relative by blood or connection by marriage of the Enrollee determined by the Carrier to be equitably entitled thereto.

(2) Reimbursement Payments for a minor child. If a child is covered as a family member under the Enrollee's self and family enrollment and is in the custody of a person other than the Enrollee, and if that other person certifies to the Carrier that he or she has custody of and financial responsibility for the dependent child, then the Carrier may issue an identification card for the dependent child(ren) to that person and may reimburse that person for any covered medical service or supply.

(3) Reimbursement Payments to family members covered under the Enrollee's self and family enrollment. If a covered child is legally responsible, or if a covered spouse is legally separated, and if the covered person does not reside with the Enrollee and certifies such conditions to the Carrier, then the Carrier may issue an identification card to the person and may reimburse that person for any covered medical service or supply. In the case of a legally separated spouse, the Carrier may also furnish the explanation of benefits to the spouse when determined by the Carrier to be required.

(4) Reimbursement payments to Government programs, such as Medicaid. If Federal law provides that reimbursement is payable to a Government program under coordination of benefits or similar rules, in lieu of being payable to the Enrollee or other covered person, the Carrier may reimburse the other Government program for any covered medical service or supply. To the degree that the Carrier is able to identify Medicaid beneficiaries, the Carrier will process claims directly to the provider of service or reimburse the Medicaid agency if the Medicaid agency has already paid the provider and is seeking reimbursement. When this situation is identified, the Carrier will update the member's records to ensure proper adjudication of claims.

(5) Any payments made in good faith in accordance with paragraphs (f)(1) through (f)(4) shall fully discharge the Carrier to the extent of such payment.

(g) *Overpayments.* If the Carrier or OPM determines that a Member's claim has been paid in error for any reason, the Carrier shall make a diligent effort to recover an overpayment to the member from the member or, if to the provider, from the provider. The Carrier shall follow general business practices and procedures in collecting debts owed under the Federal Employees Health Benefits Program. Diligent effort to recover overpayments means that upon discovering that an overpayment exists, the Carrier shall--

(1) Send a written notice of overpayment to the member or provider that provides: (A) an explanation of when and how the overpayment occurred, (B) when applicable, cite the appropriate contractual benefit provision, (C) the exact identifying information (i.e., dollar amount overpaid, date paid, check number, date of service and provider name), (D) a request for payment of the debt in full, and (E) an explanation of what may occur should the debt not be paid, including possible offset to future benefits. The notice may also offer an installment option. In addition, the Carrier shall provide the debtor with an opportunity to dispute the existence and amount of the debt before proceeding with collection activities;

(2) After confirming that the debt does exist and in the appropriate amount, send follow-up notices to the member or the provider at 30, 60 and 90 day intervals, if the debt remains unpaid and undisputed;

(3) The Carrier may off-set future benefits payable to the member or to a provider on behalf of the member to satisfy a debt due under the FEHBP if the debt remains unpaid and undisputed for 120 days after the first notice.

(4) After applying the first three steps, refer cases when it is cost effective to do so to a collection attorney or a collection agency if the debt is not recovered;

(5) Make diligent effort to recover overpayments until the debt is paid in full or determined to be uncollectible by the Carrier because it is no longer cost effective to pursue further collection efforts or it would be against equity and good conscience to continue collection efforts.

(6) Suspend recovery efforts for a debt which is based upon a claim that has been appealed as a disputed claim under Section 2.8, until the appeal has been resolved;

(7)(i) The Carrier may charge the contract for benefit payments made erroneously but in good faith provided that it can document that it acted with due diligence as described above.

(ii) Notwithstanding (g)(7)(i), the Carrier may not charge the contract for the administrative costs to correct erroneous benefit payments (or to correct processes or procedures that caused erroneous benefit payments) when the errors are egregious or repeated. These costs are deemed to be unreasonable and unallowable under section 3.2(b)(2)(ii).

(8) Maintain records that document individual unrecovered overpayment collection activities for audit or future reference.

(h) Overpayment recoveries may be reduced by any legal or collection agency fees expended to obtain the recoveries and which are not otherwise payable under this experience-rated contract. The amount credited to the contract shall be the net amount remaining after deducting the related legal or collection agency fees.

(i) Notwithstanding subsection (f), the Carrier reserves the right to pay the Member directly for all covered services described in the agreed upon brochure text attached as Appendix A.

SECTION 2.4
TERMINATION OF COVERAGE AND CONVERSION PRIVILEGES (JAN 1996)

(a) A Member's coverage is terminated as specified in regulations issued by the OPM. Benefits after termination of coverage are as specified in the regulations.

(b) A Member is entitled to a temporary continuation of coverage or an extension of coverage under the conditions and to the extent specified in the regulations.

(c) A Member whose coverage hereunder has terminated is entitled, upon application within the times and under the conditions specified in regulations, to a non-group contract regularly offered for the purpose of conversion from the contract or similar contracts. The conversion contract shall be in compliance with 5 U.S.C., chapter 89, and regulations issued thereunder.

(d) Costs associated with writing or providing benefits under conversion contracts shall not be an allowable cost of this contract.

(e) The Carrier shall maintain on file with OPM copies of the conversion policies offered to persons whose coverage under this contract terminates and advise OPM promptly of any changes in the policies. The Contracting Officer may waive this requirement where because of the large number of different conversion policies offered by the Carrier it would be impractical to maintain a complete up-to-date file of all policies. In this case the Carrier shall submit a representative sample of the general types of policies offered and provide copies of specific policies on demand.

SECTION 2.5
SUBROGATION (JAN 1997)

(a) The Carrier's subrogation rights, procedures and policies, including recovery

rights, shall be in accordance with the provisions of the agreed upon brochure text.

(b) Subrogation recoveries may be reduced by any legal fees expended to obtain the recoveries and which are not otherwise payable under this experience-rated contract. The amount credited to the contract shall be the net amount remaining after deducting the related legal fees.

SECTION 2.6
COORDINATION OF BENEFITS (JAN 2001)
(FEHBAR 1652.204-71)

(a) The Carrier shall coordinate the payment of benefits under this contract with the payment of benefits under Medicare, other group health benefits coverages, and the payment of medical and hospital costs under no-fault or other automobile insurance that pays benefits without regard to fault.

(b) The Carrier shall not pay benefits under this contract until it has determined whether it is the primary carrier or unless permitted to do so by the Contracting Officer.

(c) In coordinating benefits between plans, the Carrier shall follow the order of precedence established by the NAIC Group Coordination of Benefits Model Regulation, Rules for Coordination of Benefits, as specified by OPM.

(d) Where (1) the Carrier makes payments under this contract which are subject to COB provisions; (2) the payments are erroneous, not in accordance with the terms of the contract, or in excess of the limitations applicable under this contract; and (3) the Carrier is unable to recover such COB overpayments from the Member or the providers of services or supplies, the Contracting Officer may allow such amounts to be charged to the contract; the Carrier must be prepared to demonstrate that it has made a diligent effort to recover such COB overpayments.

(e) COB savings shall be reported by experience-rated carriers each year along with the Carrier's annual accounting statement in a form specified by OPM.

(f) Changes in the order of precedence established by the NAIC Group Coordination of Benefits Model Regulation, Rules for Coordination of Benefits, implemented after January 1 of any given year shall be required no earlier than the beginning of the following contract term.

[NOTE: In the event that benefits are payable to the Member under no-fault automobile insurance, the no-fault automobile insurer shall be the Primary Carrier if it is obligated legally to pay benefits for health care expenses without regard to other health benefits coverage that the Member may have. The term "no-fault automobile insurance" includes any automobile insurance policy under which the insurer pays benefits for health care expenses resulting from the accident without regard to whether the insured's conduct contributed to the accident.]

SECTION 2.7
DEBARMENT AND OTHER SANCTIONS
(JAN 1999)

(a) Notwithstanding 5 U.S.C. 8902(j) or any other provision of the law and regulations, if, under 5 U.S.C. 8902a, 5 CFR 970, or Public Law 103-123 (or other applicable appropriations law), a provider is barred from participating in the Program under 5 U.S.C. or the provider's services under 5 U.S.C. are excluded, the Carrier agrees that no payment shall be made by the Carrier pursuant to any contract under 5 U.S.C. (either to such provider or by reimbursement) for any service or supply furnished by such provider during the period of the debarment, except as provided in 5 CFR 970.200(h).

(b) The OPM shall notify the Carrier when a provider is barred from the FEHBP.

SECTION 2.8
FILING HEALTH BENEFIT CLAIMS/COURT REVIEW OF DISPUTED CLAIMS (MAR 1995)
(FEHBAR 1652.204-72)

(a) General. (1) The Carrier resolves claims filed under the Plan. All health benefit claims must be submitted initially to the Carrier. If the Carrier denies a claim, (or a portion of a claim), the covered individual may ask the Carrier to reconsider its denial. If the Carrier affirms its denial or fails to respond as required by paragraph (b) of this clause, the covered individual may ask OPM to review the claim. A covered individual must exhaust both the Carrier and OPM review processes specified in this clause before seeking judicial review of the denied claim.

(2) This clause applies to covered individuals and to other individuals or entities who are acting on the behalf of a covered individual and who have the covered individual's specific written consent to pursue payment of the disputed claim.

(b) Time limits for reconsidering a claim. (1) The covered individual has 6 months from the date of the notice to the covered individual that a claim (or a portion of a claim) was denied by the Carrier in which to submit a written request for reconsideration to the Carrier. The time limit for requesting reconsideration may be extended when the covered individual shows that he or she was prevented by circumstances beyond his or her control from making the request within the time limit.

(2) The Carrier has 30 days after the date of receipt of a timely-filed request for reconsideration to:

(i) Affirm the denial in writing to the covered individual;

(ii) Pay the bill or provide the service; or

(iii) Request from the covered individual or provider additional information needed to make a decision on the claim. The Carrier must simultaneously notify the covered individual of the information requested if it requests additional information from a provider. The Carrier has 30 days after the date the information is received to affirm the denial in writing to the covered individual or pay the bill or provide the service. The Carrier must make its decision based on the evidence it has if the covered individual or provider does not respond within 60 days after the date of the Carrier's notice requesting additional information. The Carrier must then send written notice to the covered individual of its decision on the claim. The covered individual may request OPM review as provided in paragraph (b)(3) of this clause if the Carrier fails to act within the time limit set forth in this paragraph.

(3) The covered individual may write to OPM and request that OPM review the Carrier's decision if the Carrier either affirms its denial of a claim or fails to respond to a covered individual's written request for reconsideration within the time limit set forth in paragraph (b)(2) of this clause. The covered individual must submit the request for OPM review within the time limit specified in paragraph (e)(1) of this clause.

(4) The Carrier may extend the time limit for a covered individual's submission of additional information to the Carrier when the covered individual shows he or she was not notified of the time limit or was prevented by circumstances beyond his or her control from submitting the additional information.

(c) Information required to process requests for reconsideration. (1) The covered individual must put the request to the Carrier to reconsider a claim in writing and give the reasons, in terms of applicable brochure provisions, that the denied claim should have been approved.

(2) If the Carrier needs additional information from the covered individual to make a decision, it must:

(i) Specifically identify the information needed;

(ii) State the reason the information is required to make a decision on the claim;

(iii) Specify the time limit (60 days after the date of the Carrier's request) for submitting the information; and

(iv) State the consequences of failure to respond within the time limit specified, as set out in paragraph (b)(2) of this section.

(d) Carrier determinations. The Carrier must provide written notice to the covered individual of its determination. If the Carrier affirms the initial denial, the notice must inform the covered individual of:

(1) The specific and detailed reasons for the denial;

(2) The covered individual's right to request a review by OPM; and

(3) The requirement that requests for OPM review must be received within 90 days after the date of the Carrier's denial notice and include a copy of the denial notice as well as documents to support the covered individual's position.

(e) OPM review. (1) If the covered individual seeks further review of the denied claim, the covered individual must make a request to OPM to review the Carrier's decision. Such a request to OPM must be made:

(i) Within 90 days after the date of the Carrier's notice to the covered individual that the denial was affirmed; or

(ii) If the Carrier fails to respond to the covered individual as provided in paragraph (b)(2) of this clause, within 120 days after the date of the covered individual's timely request for reconsideration by the Carrier; or

(iii) Within 120 days after the date the Carrier requests additional information from the covered individual, or the date the covered individual is notified that the Carrier is requesting additional information from a provider. OPM may extend the time limit for a covered individual's request for OPM review when the covered individual shows he or she was not notified of the time limit or was prevented by circumstances beyond his or her control from submitting the request for OPM review within the time limit.

(2) In reviewing a claim denied by the Carrier, OPM may

(i) Request that the covered individual submit additional information;

(ii) Obtain an advisory opinion from an independent physician;

(iii) Obtain any other information as may in its judgment be required to make a determination; or

(iv) Make its decision based solely on the information the covered individual provided with his or her request for review.

(3) When OPM requests information from the Carrier, the Carrier must release the information within 30 days after the date of OPM's written request unless a different time limit is specified by OPM in its request.

(4) Within 90 days after receipt of the request for review, OPM will either:

(i) Give a written notice of its decision to the covered individual and the Carrier; or

(ii) Notify the individual of the status of the review. If OPM does not receive requested evidence within 15 days after expiration of the applicable time limit in paragraph (e)(3) of this clause, OPM may make its decision based solely on information available to it at that time and give a written notice of its decision to the covered individual and to the Carrier.

(f) OPM, upon its own motion, may reopen its review if it receives evidence that was unavailable at the time of its original decision.

(g) Court review. (1) A suit to compel enrollment under § 890.102 of Title 5, Code of Federal Regulations, must be brought against the employing office that made the enrollment decision.

(2) A suit to review the legality of OPM's regulations under this part must be brought against the Office of Personnel Management.

(3) Federal Employees Health Benefits (FEHB) carriers resolve FEHB claims under authority of Federal statute (chapter 89, title 5, United States Code). A covered individual may seek judicial review of OPM's final action on the denial of a health benefits claim. A legal action to review final action by OPM involving such denial of health benefits must be brought against OPM and not against the Carrier or the Carrier's subcontractors. The recovery in such a suit shall be limited to a court order directing OPM to require the Carrier to pay the amount of benefits in dispute.

(4) An action under paragraph (3) of this clause to recover on a claim for health benefits:

(i) May not be brought prior to exhaustion of the administrative remedies provided in paragraphs (a) through (f) of this clause:

(ii) May not be brought later than December 31 of the 3rd year after the year in which the care or service was provided; and

(iii) Will be limited to the record that was before OPM when it rendered its decision affirming the Carrier's denial of benefits.

SECTION 2.9
CLAIMS PROCESSING (JAN 2001)

A standardized claims filing process shall be used by all FEHB carriers. The Carrier shall apply procedures for using the standard claims process. At a minimum the Carrier's program must achieve the following objectives:

(1) The majority of provider claims should be submitted electronically;

(2) All providers shall be notified that future claims must be submitted electronically, or on the Health Care Financing Administration 1500 form or the UB-92 form;

(3) The Carrier shall not use any unique provider claim form(s) for such FEHB member claims;

(4) The Carrier should reject all such claims submitted on forms other than the HCFA 1500 form or the UB-92 form and shall explain the reason on the Explanation of Benefits form; and

(5) The Carrier shall advise OPM of its progress in implementing this policy as directed by the Contracting Officer.

SECTION 2.10
CALCULATION OF COST SHARING PROVISIONS (JAN 1996)

When the Member is required to pay a specified percentage of the cost of covered services, the Member's obligation for covered services shall be based on the amount the provider has agreed to accept as full payment, including future discounts that are known and that can be accurately calculated at the time the claim is processed. This includes for example, prompt pay discounts as well as other discounts granted for various business reasons. Any discount not determined at the time of the actual adjudication shall be placed in the Special Reserve upon its determination.

SECTION 2.11
BENEFITS PAYMENTS WHEN MEDICARE IS PRIMARY (JAN 1998)

When a Member who is covered by Medicare Part A, Part B, or Parts A and B on a fee-for-service basis (a) receives services that generally are eligible for coverage by Medicare (regardless of whether or not benefits are paid by Medicare) and are covered by the Carrier, and (b) Medicare is the primary payer and the Carrier is the secondary payer for the Member under the order of benefit determination rules stated in Appendix A of this contract, then the Carrier shall limit its payment to an amount that supplements the benefits payable by Medicare (regardless of whether or not Medicare benefits are paid). When emergency services have been provided by a Medicare nonparticipating institutional provider and the provider is not reimbursed by Medicare, the Carrier shall pay its primary benefits. Payments that supplement Medicare include amounts necessary to reimburse the Member for Medicare deductibles, coinsurance, and the balance between the Medicare approved amount and the Medicare limiting charge made by non-participating providers. This provision does not apply to debarred providers (see Section 2.7).

SECTION 2.12
CONTINUING REQUIREMENTS AFTER TERMINATION OF THE CARRIER (JAN 2000)

(a) The Carrier shall fulfill all of the requirements agreed to under the contract that

continue after termination. The order of precedence for the applicable laws, regulations, and the contract are listed in Section 1.3.

(b) Contract requirements that extend beyond the date of the Carrier's termination include, but are not limited to, offering conversion contracts to enrollees during the 31-day extension of coverage for conversion, providing benefits to the enrollee until the effective date of the new enrollment, and processing and paying claims incurred prior to the termination date.

PART IV—SPECIAL PROVISIONS

SECTION 4.1
ALTERATIONS IN CONTRACT (JAN 2002)
(FAR 52.252-4)

Portions of this contract are altered as follows:

(a) Section 1.9 FEHB Quality Assurance. The following subsection is added to subsection 1.9(a):

(5) The Carrier may use the appropriate systems for measurement and/or collection of data on the quality of the health care services as described in subparagraph 1.9(a)(1).

(b) Section 1.15 Renewal and Withdrawal of Approval (FEHBAR). The following subsections are added:

(d) If the agency suspends payment of the subscription charges for any reason, the Carrier may (1) suspend making benefit payments until payment of all subscription charges due is fully restored; or (2) terminate the contract without prior notice.

(c) Section 1.21 Patient Bill of Rights. For the purpose of compliance with this Section, the Carrier will conduct the following minimum activities: (1) the Carrier will provide subscribers with a Fact Sheet that includes information about the disenrollment rate in the Blue Cross and Blue Shield Service Benefit Plan, as well as Local Plan-specific information including compliance with Federal and State financial requirements, public corporate information, years in existence, and accreditation status; (2) Provider Directories will include language advising subscribers to contact their providers directly to obtain information about the providers, including but not limited to board certifications, languages spoken, availability of interpreters, facility accessibility, and whether the provider is accepting new patients.

(d) Section 2.2 Benefits Provided. The following paragraph is added to subsection 2.2(a):

(4) The Carrier may pay the Preferred Provider Organization level of benefits under this contract to ease the hardship of members affected by natural disasters such as earthquakes, floods, etc., when because of the natural disaster members have difficulty gaining access to Preferred network providers. The Carrier may pay the Preferred level of benefits without regard to the provider's contractual relationship with the Carrier and will determine an appropriate time frame based on local conditions during which the provision of this paragraph will apply. Benefits provided under this paragraph will be made available to all members similarly affected by the natural disaster.

(e) Section 2.3 Payment of Benefits and Provision of Services and Supplies. Notwithstanding subsection (f) of Section 2.3, benefits provided under the contract are not assignable by the Member to any person without express written approval of the carrier, and in the absence of such approval, any such assignment shall be void. Notwithstanding such approval, no assignment of benefits may be made in any case prior to the time that a valid claim for benefits arises.

(f) Section 2.3 Payment of Benefits and Provision of Services and Supplies. Subsection (g)(7)(ii) of Section 2.3 is amended to read as follows: Notwithstanding (g)(7)(i), the Carrier may not charge the contract for the administrative costs to correct erroneous benefit payments (or to correct processes or procedures that caused erroneous benefit payments) when the errors are egregious and repeated. These costs are deemed to be unreasonable and unallowable under Section 2.3(b). The term "repeated" in the

previous sentence does not apply to situations in which a claims processing system error causes multiple erroneous payments or to situations that involve audit findings on errors that are endemic to the provision of insurance and claims processing.

(g) Section 2.4 Termination of Coverage and Conversion Privileges. The conversion contract set forth in Section 2.4(c) may be a contract that is regularly offered by the local Blue Cross and/or Blue Shield Plan.

(h) Section 2.5 Subrogation. The following subsections are added:

(c) To the extent that a Member has received benefits for covered services under this contract for an injury or illness caused by a third party, the Carrier shall have the right to be subrogated and succeed to any rights of recovery against any person or organization from whom the Member is legally entitled to receive all or part of those same benefits, including insurers of individual (non-group) policies of liability insurance that are issued to and in the name of the Member.

The obligation of the Carrier to recover amounts through subrogation is limited to making a reasonable effort to seek recovery of amounts to which it is entitled to recover in cases which are brought to its attention. The Carrier shall not be required to recover any amounts from any person or organization who causes an injury or illness for which the Member makes claims for benefits.

(d) The Carrier may also recover directly from the Member all amounts received by the Member by suit, settlement, or otherwise from any third party or its insurer, or the Member's insurer under an individual policy or liability insurance, for benefits which have also been paid under this contract.

(e) The Member shall take such action, furnish such information and assistance, and execute such papers as the Carrier or its representative believes are necessary to facilitate enforcement of its rights, and shall take no action which would prejudice the interests of the Carrier to subrogation.

(f) Effective January 1, 1997, all Participating Plans shall subrogate under a single, nation-wide policy to ensure equitable and consistent treatment for all Members under the contract.

(i) Section 2.6 Coordination of Benefits (FEHBAR). The following subsections are added:

(g) The benefits payable by this Plan shall be determined, on a claim by claim basis, only for those claims in excess of $100, except where Medicare is the primary payer of benefits.

(h) Whenever payments which should have been made under this contract in accordance with this provision have been made under any other group health coverage, the Carrier shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amount it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this contract and, to the extent of such payments discharged from liability under the contract.

(j) Section 3.1 Payments (FEHBAR). The following sentence is added to the end of Section 3.1(a):
OPM will withhold from the subscription charges amounts for other obligations due under the contract only to the extent that OPM and the Carrier have agreed in writing to specific deductions for such other obligations.

(k) Section 3.1 Payments (FEHBAR). The following subsection is added:

(g) Except as required pursuant to Sections 1.25 and 2.12, in the event this contract is terminated or not renewed, the

agency shall be liable for all sums due and unpaid, including subscription charges, for the period up to the last day of the Member's entitlement to benefits.

(l) Section 3.2 Accounting and Allowable Cost (FEHBAR). As required by Public Law 101-508, § 8909 of title 5, U.S.C., and Section 3.2(b)(2)(ii) of this contract are amended by the following:

(1) No tax, fee, or other monetary payment may be imposed, directly or indirectly, on a Carrier or an underwriting or plan administration subcontractor of an approved health benefits plan by any State, the District of Columbia, or the Commonwealth of Puerto Rico, or by any political subdivision or other governmental authority thereof, with respect to any payment made from the Fund.

(2) Paragraph (1) shall not be construed to exempt any Carrier or subcontractor of an approved health benefits plan from the imposition, payment, or collection of a tax, fee, or other monetary payment on the net income or profit accruing to or realized by such Carrier or underwriting or plan administration subcontractor from business conducted under this Chapter, if that tax, fee, or payment is applicable to a broad range of business activity.

(m) Section 3.2 Accounting and Allowable Cost (FEHBAR). The provision in Section 3.2(b)(2)(iv)(A) is supplemented as follows: Charges for mandatory statutory reserves (Section 3.2(b)(2)(iv)(A)) to satisfy mandatory statutory reserve requirements of Participating Plans are allowable to the extent that such requirements exceed that portion of the service charge at Appendix B, Subscription Rates, Charges, Allowances and Limitations applicable to such Plans.

(n) Section 3.2 Accounting and Allowable Cost (FEHBAR). This section is modified as follows:
The Carrier, as required by the Blue Cross and Blue Shield Service Benefit Plan Workplan, shall furnish OPM an accounting of its operations under the contract not less than 120 days after the end of the calendar year contract period.

(o) Section 3.3 Special Reserve. The provision in Section 3.3(a) is supplemented as follows:

The Special reserve held by or on behalf of the Carrier is to be used only for payment of charges against this contract, including advance payments to Participating Plans and to hospitals.

(p) Sections 5.30, 5.31, and 5.32. The Cost Accounting Standards, Chapter 1, Part 30 and Chapter 99 of the FAR, do not apply to the FEHB Program for this contract year, except to the extent compliance with specific standards is required by the cost principles in FAR Chapter 1, Subpart 31.2 and FEHBAR Subpart 1631.2.

(q) Section 3.10, Audit, Financial, and Other Information. Compliance by the Carrier and Participating Blue Cross and Blue Shield Plans with the Blue Cross Blue Shield Service Benefit Plan Workplan, as agreed upon between the Carrier and OPM, will constitute compliance with the Audit Guide referred to in Sections 3.2 and 3.10.

SECTION 4.2
HOSPITAL (FACILITY) BENEFIT PAYMENTS AND CONDITIONS (JAN 1991)

(a) Benefits described in the agreed upon brochure text shall be provided to the extent practicable in the form of services rendered by hospitals, freestanding ambulatory facilities, and home health care agencies, and payment, therefore, by or on behalf of the carrier shall constitute a complete discharge of their obligations under this contract to the extent of services rendered in accordance with the terms and conditions of the contract.

(b) Benefits for inpatient hospital care shall be available only to a Member admitted to the hospital on the recommendation, and while under the active medical supervision of a duly licensed physician or alternative

Blue Cross® and Blue Shield® Service Benefit Plan

1997

A Managed Fee-for-Service Plan with a Preferred Provider Organization and a Point-of-Service Product Administered by the Blue Cross and Blue Shield Association

Who may enroll in this Plan: All Federal employees and annuitants who are eligible to enroll in the FEHBP.

Enrollment code for this Plan:

101 High Option Self Only
102 High Option Self and Family
104 Standard Option Self Only
105 Standard Option Self and Family

Authorized for distribution by the:

Federal Employees Health Benefits Program

RI 71-5

Blue Cross® and Blue Shield® Service Benefit Plan

The Blue Cross and Blue Shield Association (Carrier), on behalf of Blue Cross and Blue Shield Plans, has entered into Contract No. CS 1039 with the Office of Personnel Management (OPM) to provide a health benefits plan (Plan) authorized by the Federal Employees Health Benefits (FEHB) law. The Plan is underwritten by Participating Blue Cross and Blue Shield Plans which administer this Plan on behalf of the Carrier and are referred to as Local Plans in this brochure. The FEHB contract specifies the manner in which it may be modified or terminated.

This brochure is based on text incorporated into the contract between OPM and the Carrier as of January 1, 1997 and is intended to be a complete statement of benefits available to FEHB members. It describes the benefits, exclusions, limitations, and maximums of the Blue Cross and Blue Shield Service Benefit Plan for 1997 and until amended by future benefit negotiations between OPM and the Carrier. It also describes procedures for obtaining benefits. You should use this brochure to determine your entitlement to benefits. However, if conflicts are discovered between the language of this brochure and the contract, the contract will control. Oral statements cannot modify the benefits described in this brochure.

An enrollee does not have a vested right to receive the benefits in this brochure in 1998 or later years, and does not have a right to benefits available prior to 1997 unless those benefits are contained in this brochure.

Inspector General Advisory: Stop Health Care Fraud!

Fraud increases the cost of health care for everyone. Anyone who intentionally makes a false statement or a false claim in order to obtain FEHB benefits or increase the amount of FEHB benefits is subject to prosecution for FRAUD which may result in CRIMINAL PENALTIES.

Please review all medical bills, medical records, and claims statements carefully. If you find that a provider, such as a doctor, hospital, pharmacy, etc., charged your Plan for services you did not receive, billed for the same service twice, or misrepresented any other information, take the following actions:

- Call the provider (doctor, hospital, etc.) and ask for an explanation—sometimes the problem is a simple error.
- If the provider does not resolve the matter, or if you remain concerned, call your Carrier at 1-800/FEP-8440 and explain the situation.
- If the matter is not resolved after speaking to your Carrier (and you still suspect fraud has been committed), call or write:

THE HEALTH CARE FRAUD HOTLINE
202/418-3300

The Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, N.W., Room 6400
Washington, DC 20415

The inappropriate use of membership identification cards, *e.g.*, to obtain benefits for a person who is not an eligible family member or after you are no longer enrolled in the Plan, is also subject to review by the Inspector General and may result in an adverse administrative action by your agency.

Using This Brochure

The **Table of Contents** will help you find the information you need to make the best use of your benefits. To get the best value for your money, you should read **Facilities and Other Providers.** It will help you understand how your choice of doctors and hospitals will affect how much you pay for services under this Plan.

This brochure explains all of your benefits. It's important that you read about your benefits so you will know what to expect when a claim is filed. Most of the benefit headings are self-explanatory. **Other Medical Benefits** and **Additional Benefits,** on the other hand, both include a variety of unrelated benefits. What is different about these benefits is how they are paid: Other Medical Benefits are generally paid after you satisfy the calendar year deductible and Additional Benefits are generally not subject to the calendar year deductible.

You will find that some benefits are listed in more than one section of the brochure. This is because how they are paid depends on which provider bills for the service. For example, physical therapy is paid differently depending on whether it is billed by an inpatient facility, a doctor, a physical therapist, or an outpatient facility.

The last part of the brochure contains information useful to you under certain circumstances. For example, if you have to go to the hospital you need to read **Precertification;** generally, hospital stays **must** be precertified for all payable benefits to apply. If you are enrolled in Medicare, take a look at **This Plan and Medicare.** And, the **Enrollment Information** section tells you about several FEHB enrollment requirements that could affect your future coverage.

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General Limitations

All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable when determined by the Carrier to be medically necessary. Coverage is provided only for services and supplies that are listed in this brochure. **No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of this brochure, convey or void any coverage, increase or reduce any benefits under the Plan or be used in the prosecution or defense of a claim under the Plan.** This brochure is based on text included in the contract between OPM and this Plan and is intended to be the complete statement of benefits available to FEHB members. You should use this brochure to determine your entitlement to benefits. However, if conflicts are discovered between the language of this brochure and the contract, the contract will control.

Other sources of benefits

This section applies when you or your family members are entitled to benefits from a source other than this Plan. You must disclose information about other sources of benefits to the Carrier and complete all necessary documents and authorizations requested by the Carrier.

Medicare

If you or a covered family member is enrolled in this Plan and Part A, Part B, or Parts A and B of Medicare, the provisions on coordination of benefits with Medicare described on pages 43-45 apply.

Group health insurance and automobile insurance

Coordination of benefits (double coverage) applies when a person covered by this Plan also has, or is entitled to benefits from, any other group health coverage, or is entitled to the payment of medical and hospital costs under no-fault or other automobile insurance that pays benefits without regard to fault. Information about the other coverage must be disclosed to this Carrier.

When there is double coverage, one plan normally pays its benefits in full as the primary payer, and the other plan pays a reduced benefit as the secondary payer. When this Plan is the secondary payer, it will pay the lesser of 1) its benefits in full, or 2) a reduced amount that, when added to the benefits payable by the other coverage, will not exceed 100% of the Covered charges for the service.

The determination of which health coverage is primary (pays its benefits first) is made according to guidelines provided by the National Association of Insurance Commissioners (NAIC). When benefits are payable under automobile insurance, including no-fault, the automobile insurer is primary (pays its benefits first) if it is legally obligated to provide benefits for health care expenses without regard to other health benefits coverage the enrollee may have.

This provision applies whether or not a claim is filed under the other coverage. When applicable, authorization must be given this Carrier to obtain information about benefits or services available from the other coverage, or to recover overpayments from other coverages.

CHAMPUS

If you are covered by both this Plan and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), this Plan will pay benefits first.

Medicaid

If you are covered by both this Plan and Medicaid, this Plan will pay benefits first.

Workers' compensation

The Plan will not pay for benefits or services required as the result of occupational disease or injury for which any medical benefits are determined by the Office of Workers Compensation Programs (OWCP) to be payable under workers' compensation (under section 8103 of title 5, U.S.C.) or by a similar agency under another Federal or State law. This provision also applies when a third party injury settlement or other similar proceeding provides medical benefits in regard to a claim under workers' compensation or similar laws. If medical benefits provided under such laws are exhausted, medical benefits may be provided for services or supplies covered by this Plan. The Plan is entitled to be reimbursed by OWCP (or the similar agency) for benefits paid by the Plan that were later found to be payable by OWCP (or the agency).

DVA facilities, DoD facilities and Indian Health Service

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from the Plan for certain services and supplies provided to you or a family member to the extent that reimbursement is required under the Federal statutes governing such facilities.

General Limitations *continued*

Other Government agencies

The Plan will not provide benefits for services and supplies paid for directly or indirectly by any other local, State, or Federal Government agency.

Liability insurance and third party actions

This subrogation and right of recovery provision applies when you or your dependent are sick or injured as a result of the act or omission of another person or party. The Plan has the right to recover payments the Plan has made to you or your dependent from a third party or third party's insurer because of illness or injury caused by a third party. In addition to its right of recovery, the Plan is subrogated to you and your dependent's present and future claims against a third party. Third party means another person or organization.

If you or your covered dependent suffer an injury or illness through the act or omission of another, you and your dependent agree: 1) to reimburse the Plan for benefits paid by the Plan in an amount not to exceed the amount of the recovery; and 2) that the Plan be subrogated to your (or your dependent's) rights to the extent of the benefits paid, including the right to bring suit. All recoveries from a third party (whether by lawsuit, settlement, or otherwise) must be used to reimburse the Plan for benefits paid. The Plan's share of the recovery will not be reduced because you or your dependent do not receive the full amount of damages claimed, unless the Plan agrees in writing to a reduction.

When you or your dependent make a claim against a third party or the third party's insurer as a result of an injury or illness for which that third party is legally responsible, the Plan shall have a lien on the proceeds of that claim in order to reimburse itself to the full amount of benefits it is called upon to pay. The Plan's lien will apply to any and all recoveries for such claim whether by court order or out-of-court settlement.

If you or your dependent are injured because of a third party's action or omission: 1) the Plan will pay benefits for that injury subject to the conditions that you and your dependent a) do not take any action that would prejudice the Plan's ability to recover benefits, and b) will cooperate in doing what is reasonably necessary to assist the Plan in any recovery; 2) the Plan's right of reimbursement extends only to the amount of Plan benefits paid or to be paid because of the injury; and 3) the Plan may insist upon an assignment of the proceeds of the claim or right of action against the third party and may withhold payment of benefits otherwise due until the assignment is provided.

You are required to notify the Plan promptly of any third party claim that you may have for damages for which the Plan has paid or may pay benefits. In addition, you are required to notify the Plan of any recovery, whether in or out of court, that you or your dependent obtain and to reimburse the Plan to the extent of benefits paid by the Plan. Any reduction of the Plan's claim for payment of attorney's fees or costs associated with the claim is subject to prior approval by the Plan.

Overpayments

The Carrier will make reasonably diligent efforts to recover benefit payments made erroneously but in good faith and may apply subsequent benefits otherwise payable to offset any overpayments.

Vested rights

An enrollee does not have a vested right to receive the benefits in this brochure in 1998 or later years, and does not have a right to benefits available prior to 1997 unless those benefits are contained in this brochure.

Limit on your costs if you're age 65 or older and don't have Medicare

The information in the following paragraphs applies to you when 1) you are not covered by either Medicare Part A (hospital insurance) or Part B (medical insurance), or both, 2) you are enrolled in this Plan as an annuitant or as a former spouse or family member covered by the family enrollment of an annuitant or former spouse, and 3) you are not employed in a position which confers FEHB coverage.

Inpatient hospital care

If you are not covered by Medicare Part A, are age 65 or older or become age 65 while receiving inpatient hospital services, and you receive care in a Medicare participating hospital, the law (5 U.S.C. 8904(b)) requires the Plan to base its payment on an amount equivalent to the amount Medicare would have allowed if you had Medicare Part A. This amount is called the equivalent Medicare amount. After the Plan pays, the law prohibits the hospital from charging you more for covered services than any deductibles, coinsurance, or copayments you owe under the Plan. Any coinsurance you owe will be based on the equivalent Medicare amount, not the actual charge.

General Limitations *continued*

Physician services

Claims for physician services provided for retired FEHB members age 65 and older who do not have Medicare Part B are also processed in accordance with 5 U.S.C. 8904(b). This law mandates the use of Medicare Part B limits for covered physician services for those members who are not covered by Medicare Part B.

The Plan is required to base its payment on the Medicare-approved amount (which is the Medicare fee schedule for the service), or the actual charge, whichever is lower. If your physician is a member of the Plan's Preferred Provider Organization (PPO) and participates with Medicare, the Plan will base its payment on the lower of these two amounts and you are responsible only for any deductible and the PPO copayment or coinsurance.

If you go to a PPO physician who does not participate with Medicare, you are responsible for any deductible and the copayment or coinsurance. In addition, you must pay the difference between the Medicare-approved amount and the limiting charge (115% of the Medicare-approved amount).

If your physician is not a Plan PPO physician but participates with Medicare, the Plan will base its regular benefit payment on the Medicare-approved amount. For instance, under this Plan's Standard Option surgical benefit, the Plan will pay 75% of the Medicare-approved amount. You will only be responsible for any deductible and coinsurance equal to 25% of the Medicare-approved amount.

If your physician does not participate with Medicare, the Plan will still base its payment on the Medicare-approved amount. However, in most cases you will be responsible for any deductible, the coinsurance or copayment amount, and any balance up to the limiting charge amount that a provider who does not participate with Medicare is legally permitted to bill under Medicare law (115% of the Medicare-approved amount).

Since a physician who participates with Medicare is only permitted to bill you up to the Medicare fee schedule amount even if you do not have Medicare Part B, it is generally to your financial advantage to use a physician who participates with Medicare.

The Carrier's explanation of benefits (EOB) will tell you how much the hospital or physician can charge you in addition to what the Plan paid. If you are billed more than the hospital or physician is allowed to charge, ask the hospital or physician to reduce the bill. If you have already paid more than you have to pay, ask for a refund. If you cannot get a reduction or refund, or are not sure how much you owe, ask the Carrier for guidance.

General Exclusions

These exclusions apply to more than one or to all benefits categories. Exclusions that are primarily identified with a single benefit category are listed along with that benefit category, but may apply to other categories. Therefore, please refer to the specific benefit sections as well to assure that you are aware of all benefit exclusions.

Benefits are provided only for services and supplies that are medically necessary (see definition). The Carrier reserves the right to determine medical necessity. The fact that a covered provider has prescribed, recommended, or approved a service or supply does not, in itself, make it medically necessary.

Benefits will not be paid for services and supplies when:

- No charge would be made if the covered individual had no health insurance coverage
- Furnished without charge (except as described on page 11); while in active military service; or required for illness or injury sustained on or after the effective date of enrollment 1) as a result of an act of war within the United States, its territories, or possessions or 2) during combat
- Furnished by immediate relatives or household members, such as spouse, parent, child, brother, or sister, by blood, marriage, or adoption
- Furnished or billed by a provider or facility that has been barred from the FEHB Program
- Furnished or billed by a noncovered facility, except that medically necessary prescription drugs are covered
- For or related to sex transformation, sexual dysfunction, or sexual inadequacy
- Not specifically listed as covered
- Experimental or investigational (see Definitions), except for the clinical trials benefit on page 19
- Not provided in accordance with accepted professional medical standards in the United States

Blue Cross® and Blue Shield® Service Benefit Plan

1998

A Managed Fee-for-Service Plan with a Preferred Provider Organization and a Point-of-Service Product Administered by the Blue Cross and Blue Shield Association

Who may enroll in this Plan: All Federal employees and annuitants who are eligible to enroll in the FEHBP.

Enrollment code for this Plan:

101 High Option Self Only
102 High Option Self and Family
104 Standard Option Self Only
105 Standard Option Self and Family

Visit this Plan's WEB page at http://www.fepblue.org

Authorized for distribution by the:

United States Office of Personnel Management

FEHB Federal Employees Health Benefits Program

RI 71-5

Blue Cross® and Blue Shield® Service Benefit Plan

The Blue Cross and Blue Shield Association (Carrier), on behalf of Blue Cross and Blue Shield Plans, has entered into Contract No. CS 1039 with the Office of Personnel Management (OPM) to provide a health benefits plan (Plan) authorized by the Federal Employees Health Benefits (FEHB) law. The Plan is underwritten by Participating Blue Cross and Blue Shield Plans which administer this Plan on behalf of the Carrier and are referred to as Local Plans in this brochure. The FEHB contract specifies the manner in which it may be modified or terminated.

This brochure is based on text incorporated into the contract between OPM and the Carrier as of January 1, 1998, and is intended to be a complete statement of benefits available to FEHB members. It describes the benefits, exclusions, limitations, and maximums of the Blue Cross and Blue Shield Service Benefit Plan for 1998 and until amended by future benefit negotiations between OPM and the Carrier. It also describes procedures for obtaining benefits. You should use this brochure to determine your entitlement to benefits. However, if conflicts are discovered between the language of this brochure and the contract, the contract will control. Oral statements cannot modify the benefits described in this brochure.

An enrollee does not have a vested right to receive the benefits in this brochure in 1999 or later years, and does not have a right to benefits available prior to 1998 unless those benefits are contained in this brochure.

Inspector General Advisory: Stop Health Care Fraud!

Fraud increases the cost of health care for everyone. Anyone who intentionally makes a false statement or a false claim in order to obtain FEHB benefits or increase the amount of FEHB benefits is subject to prosecution for FRAUD which may result in CRIMINAL PENALTIES.

Please review all medical bills, medical records, and claims statements carefully. If you find that a provider, such as a doctor, hospital, pharmacy, etc., charged your Plan for services you did not receive, billed for the same service twice, or misrepresented any other information, take the following actions:

- Call the provider (doctor, hospital, etc.) and ask for an explanation—sometimes the problem is a simple error.
- If the provider does not resolve the matter, or if you remain concerned, call your Carrier at 1-800/FEP-8440 and explain the situation.
- If the matter is not resolved after speaking to your Carrier (and you still suspect fraud has been committed), call or write:

THE HEALTH CARE FRAUD HOTLINE
202/418-3300

The Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, N.W., Room 6400
Washington, DC 20415

The inappropriate use of membership identification cards, *e.g.*, to obtain benefits for a person who is not an eligible family member or after you are no longer enrolled in the Plan, is also subject to review by the Inspector General and may result in an adverse administrative action by your agency.

When you need help with Plan benefits, or getting your ID card, call your Local Plan; check your phone book for the number. The Fraud Hotline cannot help you with these.

Using This Brochure

The **Table of Contents** will help you find the information you need to make the best use of your benefits. To get the best value for your money, you should read **Facilities and Other Providers**. It will help you understand how your choice of doctors and hospitals will affect how much you pay for services under this Plan.

This brochure explains all of your benefits. It's important that you read about your benefits so you will know what to expect when a claim is filed. Most of the benefit headings are self-explanatory. **Other Medical Benefits** and **Additional Benefits**, on the other hand, both include a variety of unrelated benefits. What is different about these benefits is how they are paid: Other Medical Benefits are generally paid after you satisfy the calendar year deductible and Additional Benefits are generally not subject to the calendar year deductible.

You will find that some benefits are listed in more than one section of the brochure. This is because how they are paid depends on which provider bills for the service. For example, physical therapy is paid differently depending on whether it is billed by an inpatient facility, a doctor, a physical therapist, or an outpatient facility.

The last part of the brochure contains information useful to you under certain circumstances. For example, if you have to go to the hospital you need to read **Precertification**; generally, hospital stays **must** be precertified for all payable benefits to apply. If you are enrolled in Medicare, take a look at **This Plan and Medicare**. And, the **Enrollment Information** section tells you about several FEHB enrollment requirements that could affect your future coverage.

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All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable when determined by the Carrier to be medically necessary. Coverage is provided only for services and supplies that are listed in this brochure. **No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of this brochure, convey or void any coverage, increase or reduce any benefits under the Plan or be used in the prosecution or defense of a claim under the Plan.** This brochure is based on text included in the contract between OPM and this Plan and is intended to be the complete statement of benefits available to FEHB members. You should use this brochure to determine your entitlement to benefits. However, if conflicts are discovered between the language of this brochure and the contract, the contract will control.

Other sources of benefits

This section applies when you or your family members are entitled to benefits from a source other than this Plan. You must disclose information about other sources of benefits to the Carrier and complete all necessary documents and authorizations requested by the Carrier.

Medicare

If you or a covered family member is enrolled in this Plan and Part A, Part B, or Parts A and B of Medicare, the provisions on coordination of benefits with Medicare described on pages 43-45 apply.

Group health insurance and automobile insurance

Coordination of benefits (double coverage) applies when a person covered by this Plan also has, or is entitled to benefits from, any other group health coverage, or is entitled to the payment of medical and hospital costs under no-fault or other automobile insurance that pays benefits without regard to fault. Information about the other coverage must be disclosed to this Carrier.

When there is double coverage, one plan normally pays its benefits in full as the primary payer, and the other plan pays a reduced benefit as the secondary payer. When this Plan is the secondary payer, it will pay the lesser of 1) its benefits in full, or 2) a reduced amount that, when added to the benefits payable by the other coverage, will not exceed 100% of the Covered charges for the service. When this Plan pays secondary, it will generally only make up the difference between the primary plan's benefit payment and this Plan's coverage. Thus, the combined payments from both plans may not equal the entire amount billed by the provider. In certain circumstances, where there is no adverse effect on the member, this Plan may also take advantage of any provider discount arrangements the primary plan may have and make up only the difference between the primary plan's payment and the amount the provider has agreed to accept as payment in full from the primary plan.

The determination of which health coverage is primary (pays its benefits first) is made according to guidelines provided by the National Association of Insurance Commissioners (NAIC). When benefits are payable under automobile insurance, including no-fault, the automobile insurer is primary (pays its benefits first) if it is legally obligated to provide benefits for health care expenses without regard to other health benefits coverage the enrollee may have.

This provision applies whether or not a claim is filed under the other coverage. When applicable, authorization must be given this Carrier to obtain information about benefits or services available from the other coverage, or to recover overpayments from other coverages.

CHAMPUS

If you are covered by both this Plan and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), this Plan will pay benefits first.

Medicaid

If you are covered by both this Plan and Medicaid, this Plan will pay benefits first.

Workers' compensation

The Plan will not pay for benefits or services required as the result of occupational disease or injury for which any medical benefits are determined by the Office of Workers Compensation Programs (OWCP) to be payable under workers' compensation (under section 8103 of title 5, U.S.C.) or by a similar agency under another Federal or State law. This provision also applies when a third party injury settlement or other similar proceeding provides medical benefits in regard to a claim under workers' compensation or similar laws. If medical benefits provided under such laws are exhausted, medical benefits may be provided for services or supplies covered by this Plan. The Plan is entitled to be reimbursed by OWCP (or the similar agency) for benefits paid by the Plan that were later found to be payable by OWCP (or the agency).

DVA facilities, DoD facilities and Indian Health Service

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from the Plan for certain services and supplies provided to you or a family member to the extent that reimbursement is required under the Federal statutes governing such facilities

General Limitations *continued*

Other Government agencies

The Plan will not provide benefits for services and supplies paid for directly or indirectly by any other local, State, or Federal Government agency.

Liability insurance and third party actions

This subrogation and right of recovery provision applies when you or your dependent are sick or injured as a result of the act or omission of another person or party. The Plan has the right to recover payments the Plan has made to you or your dependent from a third party or third party's insurer because of illness or injury caused by a third party. In addition to its right of recovery, the Plan is subrogated to you and your dependent's present and future claims against a third party. Third party means another person or organization.

If you or your covered dependent suffer an injury or illness through the act or omission of another, you and your dependent agree: 1) to reimburse the Plan for benefits paid by the Plan in an amount not to exceed the amount of the recovery; and 2) that the Plan be subrogated to your (or your dependent's) rights to the extent of the benefits paid, including the right to bring suit. All recoveries from a third party (whether by lawsuit, settlement, or otherwise) must be used to reimburse the Plan for benefits paid. The Plan's share of the recovery will not be reduced because you or your dependent do not receive the full amount of damages claimed, unless the Plan agrees in writing to a reduction.

When you or your dependent make a claim against a third party or the third party's insurer as a result of an injury or illness for which that third party is legally responsible, the Plan shall have a lien on the proceeds of that claim in order to reimburse itself to the full amount of benefits it is called upon to pay. The Plan's lien will apply to any and all recoveries for such claim whether by court order or out-of-court settlement.

If you or your dependent are injured because of a third party's action or omission: 1) the Plan will pay benefits for that injury subject to the conditions that you and your dependent a) do not take any action that would prejudice the Plan's ability to recover benefits, and b) will cooperate in doing what is reasonably necessary to assist the Plan in any recovery; 2) the Plan's right of reimbursement extends only to the amount of Plan benefits paid or to be paid because of the injury; and 3) the Plan may insist upon an assignment of the proceeds of the claim or right of action against the third party and may withhold payment of benefits otherwise due until the assignment is provided.

You are required to notify the Plan promptly of any third party claim that you may have for damages for which the Plan has paid or may pay benefits. In addition, you are required to notify the Plan of any recovery, whether in or out of court, that you or your dependent obtain and to reimburse the Plan to the extent of benefits paid by the Plan. Any reduction of the Plan's claim for payment of attorney's fees or costs associated with the claim is subject to prior approval by the Plan.

Overpayments

The Carrier will make reasonably diligent efforts to recover benefit payments made erroneously but in good faith and may apply subsequent benefits otherwise payable to offset any overpayments.

Vested rights

An enrollee does not have a vested right to receive the benefits in this brochure in 1999 or later years, and does not have a right to benefits available prior to 1998 unless those benefits are contained in this brochure.

Limit on your costs if you're age 65 or older and don't have Medicare

The information in the following paragraphs applies to you when 1) you are not covered by either Medicare Part A (hospital insurance) or Part B (medical insurance), or both, 2) you are enrolled in this Plan as an annuitant or as a former spouse or family member covered by the family enrollment of an annuitant or former spouse, and 3) you are not employed in a position which confers FEHB coverage.

Inpatient hospital care

If you are not covered by Medicare Part A, are age 65 or older or become age 65 while receiving inpatient hospital services, and you receive care in a Medicare participating hospital, the law (5 U.S.C. 8904(b)) requires the Plan to base its payment on an amount equivalent to the amount Medicare would have allowed if you had Medicare Part A. This amount is called **the equivalent Medicare amount**. After the Plan pays, the law prohibits the hospital from charging you for covered services after you have paid any deductibles, coinsurance, or copayments you owe under the Plan. Any coinsurance you owe will be based on the equivalent Medicare amount, not the actual charge. You and the Plan, together, are not legally obligated to pay the hospital more than the equivalent Medicare amount.

The Carrier's explanation of benefits (EOB) will tell you how much the hospital can charge you in addition to what the Plan paid. If you are billed more than the hospital is allowed to charge, ask the hospital to reduce the bill. If you have already paid more than you have to pay, ask for a refund. If you cannot get a reduction or refund, or are not sure how much you owe, call your Local Plan (see your phone book for the number) for assistance.

General Limitations *continued*

Physician services

Claims for physician services provided for retired FEHB members age 65 and older who do not have Medicare Part B are also processed in accordance with 5 U.S.C. 8904(b). This law mandates the use of Medicare Part B limits for covered physician services for those members who are not covered by Medicare Part B.

The Plan is required to base its payment on the **Medicare-approved amount** (which is the Medicare fee schedule for the service), or the actual charge, whichever is lower. If your physician is a member of the Plan's Preferred Provider Organization (PPO) and participates with Medicare, the Plan will base its payment on the lower of these two amounts and you are responsible only for any deductible and the PPO copayment or coinsurance.

If you go to a PPO physician who does not participate with Medicare, you are responsible for any deductible and the copayment or coinsurance. In addition, you must pay the difference between the Medicare-approved amount and the **limiting charge** (115% of the Medicare-approved amount).

If your physician is not a Plan PPO physician but participates with Medicare, the Plan will base its regular benefit payment on the Medicare-approved amount. For instance, under this Plan's **Standard Option** surgical benefit, the Plan will pay 75% of the Medicare-approved amount. You will only be responsible for any deductible and coinsurance equal to 25% of the Medicare-approved amount.

If your physician does not participate with Medicare, the Plan will still base its payment on the Medicare-approved amount. However, in most cases you will be responsible for any deductible, the coinsurance or copayment amount, **and** any balance up to the limiting charge amount (115% of the Medicare-approved amount).

Since a physician who participates with Medicare is only permitted to bill you up to the Medicare fee schedule amount even if you do not have Medicare Part B, it is generally to your financial advantage to use a physician who participates with Medicare.

The Carrier's explanation of benefits (EOB) will tell you how much the physician can charge you in addition to what the Plan paid. If you are billed more than the physician is allowed to charge, ask the physician to reduce the bill. If you have already paid more than you have to pay, ask for a refund. If you cannot get a reduction or refund, or are not sure how much you owe, call the Local Plan for assistance (see your phone book for the number).

General Exclusions

These exclusions apply to more than one or to all benefits categories. Exclusions that are primarily identified with a single benefit category are listed along with that benefit category, but may apply to other categories. Therefore, please refer to the specific benefit sections as well to assure that you are aware of all benefit exclusions.

Benefits are provided only for services and supplies that are medically necessary (see Definitions). The Carrier reserves the right to determine medical necessity. The fact that a covered provider has prescribed, recommended, or approved a service or supply does not, in itself, make it medically necessary.

Benefits will not be paid for services and supplies when:

- No charge would be made if the covered individual had no health insurance coverage
- Furnished without charge (except as described on page 11); while in active military service; or required for illness or injury sustained on or after the effective date of enrollment 1) as a result of an act of war within the United States, its territories, or possessions or 2) during combat
- Furnished by immediate relatives or household members, such as spouse, parent, child, brother, or sister, by blood, marriage, or adoption
- Furnished or billed by a provider or facility that has been barred from the FEHB Program
- Furnished or billed by a noncovered facility, except that medically necessary prescription drugs are covered
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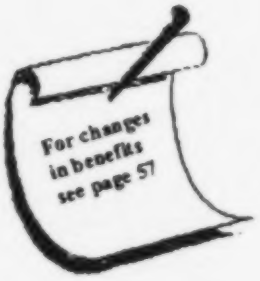
Blue Cross® and Blue Shield® Service Benefit Plan

1999

A Managed Fee-for-Service Plan with a Preferred Provider Organization and a Point-of-Service Product Administered by the Blue Cross and Blue Shield Association



Who may enroll in this Plan: All Federal employees and annuitants who are eligible to enroll in the FEHBP.

Enrollment code for this Plan:

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Visit the OPM website at http://www.opm.gov/insure

and

this Plan's website at http://www.fepblue.org

Authorized for distribution by the:

United States
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Personnel
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FEHB
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Health Benefits Program

RI 71-5

Blue Cross® and Blue Shield® Service Benefit Plan

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This brochure is the official statement of benefits on which you can rely. It describes the benefits, exclusions, limitations, and maximums of the Blue Cross and Blue Shield Service Benefit Plan for 1999 until amended by future benefit negotiations between OPM and the Carrier. It also describes procedures for obtaining benefits. You should use this brochure to determine your entitlement to benefits. Oral statements cannot modify the benefits described in this brochure.

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Get the most value for your benefit dollar.

Use a Preferred provider when selecting your health care practitioner. Your out-of-pocket expenses will be reduced and the provider will submit claims for you. Your next best choice is a Participating provider, one who accepts the Participating Provider Allowance as payment in full. If you use a Non-participating provider, your out-of-pocket costs will increase.

When you call to obtain precertification, be sure also to verify whether the hospital is a Preferred, Member, or Non-member hospital. Use of Non-member hospitals will increase your out-of-pocket costs.

General Limitations

All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable when determined by the Carrier to be medically necessary. Coverage is provided only for services and supplies that are listed in this brochure. **No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of this brochure, convey or void any coverage, increase or reduce any benefits under the Plan or be used in the prosecution or defense of a claim under the Plan.** This brochure is the official statement of benefits on which you can rely.

Other sources of benefits

This section applies when you or your family members are entitled to benefits from a source other than this Plan. You must disclose information about other sources of benefits to the Carrier and complete all necessary documents and authorizations requested by the Carrier.

Medicare

If you or a covered family member is enrolled in this Plan and Part A, Part B, or Parts A and B of Medicare, the provisions on coordination of benefits with Medicare described on pages 43-45 apply.

Group health insurance and automobile insurance

Coordination of benefits (double coverage) applies when a person covered by this Plan also has, or is entitled to benefits from, any other group health coverage, or is entitled to the payment of medical and hospital costs under no-fault or other automobile insurance that pays benefits without regard to fault. Information about the other coverage must be disclosed to this Carrier.

When there is double coverage, one plan normally pays its benefits in full as the primary payer, and the other plan pays a reduced benefit as the secondary payer. When this Plan is the secondary payer, it will pay the lesser of 1) its benefits in full, or 2) a reduced amount that, when added to the benefits payable by the other coverage, will not exceed 100% of the Covered charges for the service. When this Plan pays secondary, it will generally only make up the difference between the primary plan's benefit payment and this Plan's coverage subject to this Plan's applicable deductibles, coinsurance and copayments (see pages 43-44 for exceptions when Medicare is the primary payer). Thus, the combined payments from both plans may not equal the entire amount billed by the provider. In certain circumstances, where there is no adverse effect on the member, this Plan may also take advantage of any provider discount arrangements the primary plan may have and make up only the difference between the primary plan's payment and the amount the provider has agreed to accept as payment in full from the primary plan. When this Plan pays secondary to primary coverage you may have from a prepaid plan, this Plan's benefits will be determined based on your out-of-pocket liability under the prepaid plan (generally the prepaid plan's copayment), and subject to this Plan's deductibles, coinsurance and copayments (see page 44 for exceptions when a Medicare prepaid plan is the primary payer).

The determination of which health coverage is primary (pays its benefits first) is made according to guidelines provided by the National Association of Insurance Commissioners (NAIC). When benefits are payable under automobile insurance, including no-fault, the automobile insurer is primary (pays its benefits first) if it is legally obligated to provide benefits for health care expenses without regard to other health benefits coverage the enrollee may have.

This provision applies whether or not a claim is filed under the other coverage. When applicable, authorization must be given this Carrier to obtain information about benefits or services available from the other coverage, or to recover overpayments from other coverages.

CHAMPUS

If you are covered by both this Plan and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), this Plan will pay benefits first.

Medicaid

If you are covered by both this Plan and Medicaid, this Plan will pay benefits first.

Workers' compensation

The Plan will not pay for benefits or services required as the result of occupational disease or injury for which any medical benefits are determined by the Office of Workers Compensation Programs (OWCP) to be payable under workers' compensation (under section 8103 of title 5, U.S.C.) or by a similar agency under another Federal or State law. This provision also applies when a third party injury settlement or other similar proceeding provides medical benefits in regard to a claim under workers' compensation or similar laws. If medical benefits provided under such laws are exhausted, medical benefits may be provided for services or supplies covered by this Plan. The Plan is entitled to be reimbursed by OWCP (or the similar agency) for benefits paid by the Plan that were later found to be payable by OWCP (or the agency).

DVA facilities, DoD facilities and Indian Health Service

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from the Plan for certain services and supplies provided to you or a family member to the extent that reimbursement is required under the Federal statutes governing such facilities.

General Limitations *continued*

Other Government agencies

The Plan will not provide benefits for services and supplies paid for directly or indirectly by any other local, State, or Federal Government agency.

Liability insurance and third party actions

This subrogation and right of recovery provision applies when you or your dependent are sick or injured as a result of the act or omission of another person or party. The Plan has the right to recover payments the Plan has made to you or your dependent from a third party or third party's insurer because of illness or injury caused by a third party. In addition to its right of recovery, the Plan is subrogated to you and your dependent's present and future claims against a third party. Third party means another person or organization.

If you or your covered dependent suffer an injury or illness through the act or omission of another, you and your dependent agree: 1) to reimburse the Plan for benefits paid by the Plan in an amount not to exceed the amount of the recovery; and 2) that the Plan be subrogated to your (or your dependent's) rights to the extent of the benefits paid, including the right to bring suit. All recoveries from a third party (whether by lawsuit, settlement, or otherwise) must be used to reimburse the Plan for benefits paid. The Plan's share of the recovery will not be reduced because you or your dependent do not receive the full amount of damages claimed, unless the Plan agrees in writing to a reduction.

When you or your dependent make a claim against a third party or the third party's insurer as a result of an injury or illness for which that third party is legally responsible, the Plan shall have a lien on the proceeds of that claim in order to reimburse itself to the full amount of benefits it is called upon to pay. The Plan's lien will apply to any and all recoveries for such claim whether by court order or out-of-court settlement.

If you or your dependent are injured because of a third party's action or omission: 1) the Plan will pay benefits for that injury subject to the conditions that you and your dependent a) do not take any action that would prejudice the Plan's ability to recover benefits, and b) will cooperate in doing what is reasonably necessary to assist the Plan in any recovery; 2) the Plan's right of reimbursement extends only to the amount of Plan benefits paid or to be paid because of the injury; and 3) the Plan may insist upon an assignment of the proceeds of the claim or right of action against the third party and may withhold payment of benefits otherwise due until the assignment is provided.

You are required to notify the Plan promptly of any third party claim that you may have for damages for which the Plan has paid or may pay benefits. In addition, you are required to notify the Plan of any recovery, whether in or out of court, that you or your dependent obtain and to reimburse the Plan to the extent of benefits paid by the Plan. Any reduction of the Plan's claim for payment of attorney's fees or costs associated with the claim is subject to prior approval by the Plan.

Overpayments

The Carrier will make reasonably diligent efforts to recover benefit payments made erroneously but in good faith and may apply subsequent benefits otherwise payable to offset any overpayments.

Vested rights

An enrollee does not have a vested right to receive the benefits in this brochure in 2000 or later years, and does not have a right to benefits available prior to 1999 unless those benefits are contained in this brochure.

Limit on your costs if you're age 65 or older and don't have Medicare

The information in the following paragraphs applies to you when 1) you are not covered by either Medicare Part A (hospital insurance) or Part B (medical insurance), or both, 2) you are enrolled in this Plan as an annuitant or as a former spouse or family member covered by the family enrollment of an annuitant or former spouse, and 3) you are not employed in a position which confers FEHB coverage.

Inpatient hospital care

If you are not covered by Medicare Part A, are age 65 or older or become age 65 while receiving inpatient hospital services, and you receive care in a Medicare participating hospital, the law (5 U.S.C. 8904(b)) requires the Plan to base its payment on an amount equivalent to the amount Medicare would have allowed if you had Medicare Part A. This amount is called the **equivalent Medicare amount**. After the Plan pays, the law prohibits the hospital from charging you for covered services after you have paid any deductibles, coinsurance, or copayments you owe under the Plan. Any coinsurance you owe will be based on the equivalent Medicare amount, not the actual charge. You and the Plan, together, are not legally obligated to pay the hospital more than the equivalent Medicare amount.

The Carrier's explanation of benefits (EOB) will tell you how much the hospital can charge you in addition to what the Plan paid. If you are billed more than the hospital is allowed to charge, ask the hospital to reduce the bill. If you have already paid more than you have to pay, ask for a refund. If you cannot get a reduction or refund, or are not sure how much you owe, call your Local Plan at the telephone number on the back of your identification card for assistance.

General Limitations *continued*

Physician services

Claims for physician services provided for retired FEHB members age 65 and older who do not have Medicare Part B are also processed in accordance with 5 U.S.C. 8904(b). This law mandates the use of Medicare Part B limits for covered physician services for those members who are not covered by Medicare Part B.

The Plan is required to base its payment on the **Medicare-approved amount** (which is the Medicare fee schedule for the service), or the actual charge, whichever is lower. If your physician is a member of the Plan's Preferred Provider Organization (PPO) and participates with Medicare, the Plan will base its payment on the lower of these two amounts and you are responsible only for any deductible and the PPO copayment or coinsurance.

If you go to a PPO physician who does not participate with Medicare, you are responsible for any deductible and the copayment or coinsurance. In addition, you must pay the difference between the Medicare-approved amount and the **limiting charge** (115% of the Medicare-approved amount).

If your physician is not a Plan PPO physician but participates with Medicare, the Plan will base its regular benefit payment on the Medicare-approved amount. For instance, under this Plan's **Standard Option** surgical benefit, the Plan will pay 75% of the Medicare-approved amount. You will only be responsible for any deductible and coinsurance equal to 25% of the Medicare-approved amount.

If your physician does not participate with Medicare, the Plan will still base its payment on the Medicare-approved amount. However, in most cases you will be responsible for any deductible, the coinsurance or copayment amount, and any balance up to the limiting charge amount (115% of the Medicare-approved amount).

Since a physician who participates with Medicare is only permitted to bill you up to the Medicare fee schedule amount even if you do not have Medicare Part B, it is generally to your financial advantage to use a physician who participates with Medicare.

The Carrier's explanation of benefits (EOB) will tell you how much the physician can charge you in addition to what the Plan paid. If you are billed more than the physician is allowed to charge, ask the physician to reduce the bill. If you have already paid more than you have to pay, ask for a refund. If you cannot get a reduction or refund, or are not sure how much you owe, call your Local Plan at the telephone number on the back of your identification card for assistance.

General Exclusions

These exclusions apply to more than one or to all benefits categories. Exclusions that are primarily identified with a single benefit category are listed along with that benefit category, but may apply to other categories. Therefore, please refer to the specific benefit sections as well to assure that you are aware of all benefit exclusions.

Benefits are provided only for services and supplies that are medically necessary (see Definitions). The Carrier reserves the right to determine medical necessity. The fact that a covered provider has prescribed, recommended, or approved a service or supply does not, in itself, make it medically necessary.

Benefits will not be paid for services and supplies when:

- No charge would be made if the covered individual had no health insurance coverage
- Furnished without charge (except as described on page 11); while in active military service; or required for illness or injury sustained on or after the effective date of enrollment 1) as a result of an act of war within the United States, its territories, or possessions or 2) during combat
- Furnished by immediate relatives or household members, such as spouse, parent, child, brother, or sister, by blood, marriage, or adoption
- Furnished or billed by a provider or facility that has been barred from the FEHB Program
- Furnished or billed by a noncovered facility, except that medically necessary prescription drugs are covered
- For or related to sex transformation, sexual dysfunction, or sexual inadequacy
- Not specifically listed as covered
- Experimental or investigational (see Definitions), except for devices classified by the U.S. Food and Drug Administration as Category B Non-experimental/Investigational Devices and the clinical trials benefit on page 19
- Not provided in accordance with accepted professional medical standards in the United States

Blue Cross® and Blue Shield® Service Benefit Plan

2000

A Fee-for-Service Plan with a Preferred Provider Organization and a Point-of-Service Product

Administered by the Blue Cross and Blue Shield Association

Who may enroll in this Plan: All Federal employees and annuitants who are eligible to enroll in the FEHBP.

Enrollment code for this Plan:

101 High Option Self Only
102 High Option Self and Family
104 Standard Option Self Only
105 Standard Option Self and Family

Visit the OPM website at http://www.opm.gov/insure

and

our website at http://www.fepblue.org

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United States Office of
Personnel Management
Retirement and
Insurance Service

FEHB
Federal Employees
Health Benefits Program

RI 71-005

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Introduction

Blue Cross® and Blue Shield® Service Benefit Plan

This brochure describes the benefits you can receive from the Blue Cross and Blue Shield Service Benefit Plan under its contract (CS 1039) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits (FEHB) law. This Plan is underwritten by Participating Blue Cross and Blue Shield Plans which administer this Plan on behalf of the Blue Cross and Blue Shield Association and are referred to as Local Plans in this brochure.

This brochure is the official statement of benefits on which you can rely. A person enrolled in this Plan is entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits. Nothing anyone says can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

Because OPM negotiates benefits and premiums annually they change each year. This brochure describes the only benefits available to you under this Plan in 2000. Benefit changes are effective January 1, 2000, and are shown on pages 4-5. You do not have a right to benefits that were available before January 1, 2000 unless those benefits are also contained in this brochure. Premiums are listed at the end of this brochure.

Plain language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. Health plan representatives and Office of Personnel Management staff have worked cooperatively to make portions of this brochure clearer. In it you will find common, everyday words, except for necessary technical terms; "you" and other personal pronouns; active voice; and short sentences.

We refer to the Blue Cross and Blue Shield Service Benefit Plan as "this Plan" throughout this brochure even though in other legal documents, you will see a plan referred to as a carrier.

Sections one, two, four, and ten are now in plain language, as well as portions of sections three and eight. We will rewrite the remaining sections of this brochure, including the benefits section, for year 2001. Please note that the format and organization of this brochure have changed as well.

These changes do not affect the benefits or services we provide. We have rewritten this brochure only to make it more understandable.

How to use this brochure

This brochure has ten sections. Each section has important information you should read. If you want to compare this Plan's benefits with benefits from other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

1. Fee-for-Service Plans (FFS). This Plan is a FFS plan. Turn to this section for a brief description of Fee-for-Service plans and how they work.
2. How we change for 2000. If you are a current member and want to see how we have changed, read this section.
3. How to get benefits. Make sure you read this section; it tells you how to get benefits and how we operate.
4. What if we deny your claim or request for pre-authorization? This section tells you what to do if you disagree with our decision not to pay for your claim or to deny your request for a service.
5. Benefits. Look here to see the benefits we will provide as well as specific exclusions and limitations. You will also find information about non-FEHB benefits.
6. How to file a claim. Look here to find specific information on how to file claims with us.
7. General exclusions - Things we don't cover. Look here to see benefits that we will not provide.
8. Limitations - Rules that affect your benefits. This section describes limits that can affect your benefits.
9. Fee-for-Service Facts. This section contains information about precertification, protection against catastrophic expenses, and a definitions section.
10. FEHB Facts. Read this for information about the Federal Employees Health Benefits (FEHB) Program.

Section 1. Fee-for-Service Plans

Fee-for-Service plans reimburse you or your provider for covered services. They do not typically provide or arrange for health care. Fee-for-Service plans let you choose your own physicians, hospitals, and other health care providers.

The FFS plan reimburses you for your health care expenses, usually on a percentage basis. These percentages, as well as deductibles, methods for applying deductibles to families, and the percentage of coinsurance you must pay vary by plan. The type and extent of covered services vary by plan. There is a detailed explanation of the benefits we offer in this brochure; you should read it carefully.

This FFS plan offers a Preferred provider organization (PPO) arrangement. This arrangement with health care providers gives you enhanced benefits or limits your out-of-pocket expenses.

Section 2. How we change for 2000

Program-wide changes

To keep your premium as low as possible OPM has set a minimum copayment of $10 for all primary care office visits.

This year, you have a right to more information about this Plan, care management, our networks, facilities, and providers.

If you have a chronic or disabling condition or are in the second or third trimester of pregnancy, and your provider is leaving our PPO network at our request without cause, we will notify you. You may continue to receive our PPO level of benefits for your specialist's services for up to 90 days after you receive notice. We will provide regular non-PPO benefits for the specialist's services after the 90-day period expires.

You may review and obtain copies of your medical records on request. If you want copies of your medical records, ask your health care provider for them. You may ask that a physician amend a record that is not accurate, not relevant, or incomplete. If the physician does not amend your record, you may add a brief statement to it. If they do not provide you your records, call us and we will assist you.

If you are over age 50, all FEHB plans cover a screening sigmoidoscopy every five years. This screening is for colorectal cancer.

Changes to this Plan

Your share of the **High Option** Blue Cross and Blue Shield Service Benefit Plan premium will increase by 4.3% for Self Only or 3.6% for Self and Family.

Your share of the **Standard Option** Blue Cross and Blue Shield Service Benefit Plan premium will increase by 8.0% for Self Only or 7.2% for Self and Family.

We have eliminated the $50 prescription drug deductible applicable to drugs obtained from retail pharmacies under **both options**.

We no longer waive the copayment for prescription drugs obtained through the mail for members with Medicare Part B as primary payer. Under **High Option**, all members now pay $8 for generic and $14 for brand-name prescription drugs and supplies obtained through the Mail Service Prescription Drug Program. Under **Standard Option**, all members now pay $12 for generic and $20 for brand-name prescription drugs and supplies obtained through the mail. See pages 34-35.

Under **High Option**, we no longer waive or reduce the coinsurance for prescription drugs obtained from a retail pharmacy for members with Medicare Part B as primary payer, and all members will pay 15% PPA at Preferred retail pharmacies and 35% AWP at Non-preferred retail pharmacies. Previously, when Medicare Part B was the primary payer, the 15% PPA coinsurance at Preferred pharmacies was waived and the 35% AWP coinsurance at Non-preferred pharmacies was reduced to 15% AWP. See pages 34-35.

Under **Standard Option**, you now pay 25% PPA at Preferred retail pharmacies and 45% AWP at Non-preferred retail pharmacies. Previously, coinsurance was 20% PPA at Preferred retail pharmacies and 40% AWP at Non-preferred retail pharmacies. See pages 34-35.

Under **Standard Option**, we no longer waive or reduce the coinsurance for prescription drugs obtained from a retail pharmacy for members with Medicare Part B as primary payer who are confined to a nursing home. Previously, the 20% PPA coinsurance at Preferred retail pharmacies was waived and the 40% AWP coinsurance at Non-preferred retail pharmacies was reduced to 20% AWP. See pages 34-35.

How to claim benefits

In most cases, when services are covered by both Medicare and this Plan, Medicare is the primary payer if you are an annuitant and this Plan is the primary payer if you are an employee. When Medicare is the primary payer, your claims should first be submitted to Medicare. To be sure your claims are processed by this Carrier, you must submit the Medicare Summary Notice (MSN) and duplicates of all bills along with a completed claim form. The Carrier will not process your claim without knowing whether you have Medicare and, if you do, without receiving the Medicare Summary Notice (MSN).

Claims should show both your Plan identification number (8 digits preceded by "R") and your Medicare identification number which is on your Medicare card. Claims for benefits which are not covered by Medicare should be sent directly to your Local Plan. See page 40 for information on how retail pharmacy-obtained drug expenses are filed.

Other group insurance coverage

When anyone has coverage with us and with another group health plan it is called double coverage. You must tell us if you or a family member has double coverage. You must also send us documents about other insurance if we ask for them.

When you have double coverage, one plan is the primary payer; it pays benefits first. The other plan is secondary; it pays benefits next. We decide which insurance is primary according to the National Association of Insurance Commissioners' Guidelines.

If we pay second, we will determine how much of the charge we will pay for. After the first plan pays, we will pay either what is left of our allowable charge or our regular benefit, whichever is less. We will not pay more than our allowable charge. When we pay secondary, we will generally only make up the difference between the primary plan's benefit payment and 100% of our allowable charge, subject to our applicable deductibles, coinsurance and copayments (see pages 43-44 for exceptions when Medicare is primary payer). Thus, the combined payments from both plans may not equal the entire amount billed by the provider. In certain circumstances when we are secondary, and there is no adverse effect on you, we may also take advantage of any provider discount arrangements the primary plan may have and only make up the difference between the primary plan's payment and the amount the provider has agreed to accept as payment in full from the primary plan. When we are secondary to primary coverage you may have from a prepaid plan, our benefits will be based on your out-of-pocket liability under the prepaid plan (generally the prepaid plan's copayment) subject to our deductibles, coinsurance, and copayments (see page 44 for exceptions.)

Remember: Even if you do not file a claim with your other plan, you must still tell us that you have double coverage.

When others are responsible for injuries

This subrogation and right of recovery provision applies when you or your dependent are sick or injured as a result of the act or omission of another person or party. We have the right to recover payments we have made to you or your dependent from a third party or third party's insurer because of illness or injury caused by a third party. In addition to our right of recovery, we are subrogated to you and your dependent's present and future claims against a third party. Third party means another person or organization.

If you or your covered dependent suffer an injury or illness through the act or omission of another, you and your dependent agree: 1) to reimburse us for benefits we paid in an amount not to exceed the amount of the recovery; and 2) that we will be subrogated to your (or your dependent's) rights to the extent of the benefits paid, including the right to bring suit. All recoveries from a third party (whether by lawsuit, settlement, or otherwise) must be used to reimburse us for benefits paid. Our share of the recovery will not be reduced because you or your dependent do not receive the full amount of damages claimed, unless we agree in writing to a reduction.

When you or your dependent make a claim against a third party or the third party's insurer as a result of an injury or illness for which that third party is legally responsible, we shall have a lien on the proceeds of that claim in order to reimburse ourselves to the full amount of benefits we are called upon to pay. Our lien will apply to any and all recoveries for such claim whether by court order or out-of-court settlement.

If you or your dependent are injured because of a third party's action or omission: 1) we will pay benefits for that injury subject to the conditions that you and your dependent a) do not take any action that would prejudice our ability to recover benefits, and b) will cooperate in doing what is reasonably necessary to assist us in any recovery; 2) our right of reimbursement extends only to the amount of Plan benefits paid or to be paid because of the injury; and 3) we may insist upon an assignment of the proceeds of the claim or right of action against the third party and may withhold payment of benefits otherwise due until the assignment is provided.

You are required to notify us promptly of any third party claim that you may have for damages for which we have paid or may pay benefits. In addition, you are required to notify us of any recovery, whether in or out of court, that you or your dependent obtain and to reimburse us to the extent of benefits paid by us. Any reduction of our claim for payment of attorney's fees or costs associated with the claim is subject to prior approval by us.

TRICARE

TRICARE is the health care program for members, eligible dependents, and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we are the primary payer. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

Workers' compensation

We do not cover services that:

- You need because of a workplace-related disease or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determine they must provide;
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once the OWCP or similar agency has paid its maximum benefits for your treatment, we will provide your benefits.

Medicaid

We pay first if both Medicaid and this Plan cover you.

Other Government Agencies

We do not cover services and supplies that a local, State, or Federal Government agency directly or indirectly pays for.

Overpayments

We will make reasonably diligent efforts to recover benefit payments made erroneously but in good faith and may apply subsequent benefits otherwise payable to offset any overpayments.

Limit on your costs if you're age 65 or older and don't have Medicare

The information in the following paragraphs applies to you when 1) you are not covered by either Medicare Part A (hospital insurance) or Part B (medical insurance), or both, 2) you are enrolled in this Plan as an annuitant or as a former spouse or family member covered by the family enrollment of an annuitant or former spouse, and 3) you are not employed in a position which confers FEHB coverage.

Inpatient hospital care

If you are not covered by Medicare Part A, are age 65 or older or become age 65 while receiving inpatient hospital services, and you receive care in a Medicare participating hospital, the law (5 U.S.C. 8904(b)) requires the Plan to base its payment on an amount equivalent to the amount Medicare would have allowed if you had Medicare Part A. This amount is called **the equivalent Medicare amount**. After the Plan pays, the law prohibits the hospital from charging you for covered services after you have paid any deductibles, coinsurance, or copayments you owe under the Plan. Any coinsurance you owe will be based on the equivalent Medicare amount, not the actual charge. You and the Plan, together, are not legally obligated to pay the hospital more than the equivalent Medicare amount.

The Carrier's explanation of benefits (EOB) will tell you how much the hospital can charge you in addition to what the Plan paid. If you are billed more than the hospital is allowed to charge, ask the hospital to reduce the bill. If you have already paid more than you have to pay, ask for a refund. If you cannot get a reduction or refund, or are not sure how much you owe, call your Local Plan at the telephone number on the back of your identification card for assistance.

Physician services

Claims for physician services provided for retired FEHB members age 65 and older who do not have Medicare Part B are also processed in accordance with 5 U.S.C. 8904(b). This law mandates the use of Medicare Part B limits for covered physician services for those members who are not covered by Medicare Part B.

The Plan is required to base its payment on the **Medicare-approved amount** (which is the Medicare fee schedule for the service), or the actual charge, whichever is lower. If your physician is a member of the Plan's Preferred Provider Organization (PPO) and participates with Medicare, the Plan will base its payment on the lower of these two amounts and you are responsible only for any deductible and the PPO copayment or coinsurance.

If you go to a PPO physician who does not participate with Medicare, you are responsible for any deductible and the copayment or coinsurance. In addition, unless the provider's agreement with the Local Plan specifies otherwise, you must pay the difference between the Medicare-approved amount and the **limiting charge** (115% of the Medicare-approved amount).

If your physician is not a Plan PPO physician but participates with Medicare, the Plan will base its regular benefit payment on the Medicare-approved amount. For instance, under this Plan's **Standard Option** surgical benefit, the Plan will pay 75% of the Medicare-approved amount. You will only be responsible for any deductible and coinsurance equal to 25% of the Medicare-approved amount.

If your physician does not participate with Medicare, the Plan will still base its payment on the Medicare-approved amount. However, in most cases you will be responsible for any deductible, the coinsurance or copayment amount, **and** any balance up to the limiting charge amount (115% of the Medicare-approved amount).

Since a physician who participates with Medicare is only permitted to bill you up to the Medicare fee schedule amount even if you do not have Medicare Part B, it is generally to your financial advantage to use a physician who participates with Medicare.

The Carrier's explanation of benefits (EOB) will tell you how much the physician can charge you in addition to what the Plan paid. If you are billed more than the physician is allowed to charge, ask the physician to reduce the bill. If you have already paid more than you have to pay, ask for a refund. If you cannot get a reduction or refund, or are not sure how much you owe, call your Local Plan at the telephone number on the back of your identification card for assistance.

Section 9. Fee-for-Service Facts

Precertification

Precertification evaluates the medical necessity of proposed admissions and the number of days required to treat your condition. You are responsible for ensuring that the precertification requirement is met. You or your doctor must check with your Plan before being admitted to the hospital. If that doesn't happen, your Plan will reduce benefits by $500. Be a responsible consumer. Be aware of your Plan's cost containment provisions. You can avoid penalties and keep premiums under control by following the procedures specified in this subsection.

Precertify before admission

Precertification is not a guarantee of benefit payments. Precertification of an inpatient admission is a predetermination that, based on the information given, the admission meets the medical necessity requirements of the Plan. **It is your responsibility to ensure that precertification is obtained.** If precertification is not obtained and benefits are otherwise payable, benefits for the admission will be reduced by $500. When you call to obtain precertification, be sure also to verify whether the hospital is a Preferred, Member or Non-member hospital.

To precertify a scheduled admission:

- You, your representative, your physician, or your hospital must call the Local Plan prior to admission.
- Provide the following information: enrollee's name and Plan identification number; patient's name, birth date, and phone number; reason for hospitalization, proposed treatment, or surgery; name of hospital or facility; name and phone number of admitting physician; and number of planned days of confinement.

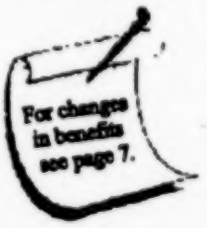
The Local Plan will then tell the physician and/or hospital the number of approved days of confinement for the care of the patient's condition. Written confirmation of the certification decision will be sent to you, your physician, and the hospital. If the length of stay needs to be extended, follow the procedures below.

Blue Cross and Blue Shield Service Benefit Plan

http://www.fepblue.org

2001

A fee-for-service plan with a preferred provider organization and a point-of-service product



Sponsored and administered by: The Blue Cross and Blue Shield Association and participating local Blue Cross and Blue Shield Plans

Who may enroll in this Plan: All Federal employees and annuitants who are eligible to enroll in the FEHBP

Enrollment codes for this Plan:

101 High Option - Self Only
102 High Option - Self and Family
104 Standard Option - Self Only
105 Standard Option - Self and Family

RI 71-005

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Introduction

Blue Cross and Blue Shield Service Benefit Plan
1310 G Street, NW, Suite 900
Washington, DC 20005

This Plan is underwritten by participating Blue Cross and Blue Shield Plans (Local Plans) that administer this Plan on behalf of the Blue Cross and Blue Shield Association (the Carrier).

This brochure describes the benefits of the **Blue Cross and Blue Shield Service Benefit Plan** under our contract (CS 1039) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits (FEHB) law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2001, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2001, and are summarized on pages 7 and 8. Rates are shown at the end of this brochure.

Plain Language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. In response, a team of health plan representatives and OPM staff worked cooperatively to make this brochure clearer. Except for necessary technical terms, we use common words. "You" means the enrollee or family member; "we" means the Blue Cross and Blue Shield Service Benefit Plan or the local Blue Cross and Blue Shield Plans that administer it.

The plain language team reorganized the brochure and the way we describe our benefits. When you compare this Plan with other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

If you have comments or suggestions about how to improve this brochure, let us know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure, or e-mail us at fehbwebcomments@opm.gov, or write to OPM at the Insurance Planning and Evaluation Division, P.O. Box 436, Washington, DC 20044-0436.

Section 1. Facts about this fee-for-service plan

This Plan is a fee-for-service (FFS) plan. You can choose your own hospitals, physicians, and other professional health care providers.

We reimburse you or your provider for your covered services, usually based on a percentage of the amount we allow. The type and extent of covered services, and the amount we allow, may be different from other plans. Read brochures carefully.

We have Preferred Provider Organizations (PPO):

Our fee-for-service plan offers services through a PPO. When you use our PPO providers, you will receive covered services at a reduced cost. Your Local Plan (or for retail pharmacies, PCS Health Systems, Inc.) is solely responsible for the selection of PPO providers in your area. Contact your Local Plan for the names of PPO providers and to verify their continued participation. You can also go to our web page, which you can reach through the FEHB web site, www.opm.gov/insure. Do not call OPM or your agency for our provider directory. Contact your Local Plan to request a PPO directory.

PPO benefits apply only when you use a PPO provider. PPO networks may be more extensive in some areas than in others. We cannot guarantee the availability of every specialty in all areas. If no PPO provider is available, or you do not use a PPO provider, the standard non-PPO benefits apply.

We also have Point-of-Service (POS) benefits:

In certain areas, our fee-for-service plan offers POS benefits to members who select Standard Option. This means you can get better benefits at less out-of-pocket costs by signing up with us for the POS program, selecting a contracted POS primary care physician (PCP), and letting the PCP manage your care. In Minnesota and North Dakota, you select a primary care clinic rather than a primary care physician. If you go to another provider without a referral from your PCP, we will provide only regular Standard Option non-PPO benefits. We offer the POS program in the following areas: Connecticut, Georgia, Kansas, Louisiana (New Orleans area), Massachusetts, Minnesota, New Jersey, New York (areas served by the Empire Plan), North Dakota (Fargo area), and Oklahoma. You can obtain a brochure addendum from your Local Plan in these areas that describes our POS service areas, benefit levels, and special requirements.

How we pay professional and facility providers:

We pay benefits when we receive a claim for covered services. Each Local Plan contracts with hospitals and other health care facilities, physicians, and non-physician health care professional providers in its service area, and is responsible for processing and paying claims for services you receive within that area. Most, but not all, of these contracted providers are in our PPO network.

- **PPO providers.** PPO providers have agreed to accept a specific negotiated amount as payment in full for services provided to you. We refer to PPO facility and professional providers as "Preferred." They will generally bill the Local Plan directly, who will then pay them directly. You do not file a claim. Your out-of-pocket costs are generally less when you receive services from PPO providers, and are limited to your applicable deductible, and coinsurance or copayments, for covered services. We provide benefits for some services (such as a routine physical exam) only when you use PPO providers.

- **Participating providers.** Some Local Plans also contract with other providers that are not in our PPO network. If they are professionals, we refer to them as "Participating" providers, and if they are facilities, we refer to them as "Member" facilities. They have agreed to accept a different negotiated amount than our PPO providers as payment in full. They will also generally file your claims for you. They have agreed not to bill you for more than your applicable deductible, and coinsurance or copayments, for covered services. We pay them directly, but at our non-PPO benefit levels. Your out-of-pocket costs will be greater than if you use PPO providers.

  Note: Not all areas have participating providers and/or member facilities. To verify the status of a provider, please contact the Local Plan serving the area where the services are to be performed.

- **Non-participating providers.** Providers who are not PPO or Participating providers do not have contracts with us, and may or may not accept our allowance. We refer to them as "Non-participating providers" generally, although if they are facilities we may refer to them as "Non-member facilities." When you use Non-participating providers, you may have to file your claim with us. We will then pay our benefits to you, and you must pay the provider.

  You must pay any difference between the amount Non-participating providers charge and our allowance, in addition to any applicable coinsurance amounts, copayment amounts, amounts applied to your calendar year deductible, and amounts for noncovered services. **Important: Your out-of-pocket costs may be substantially higher when you use Non-participating providers than when you use PPO or Participating providers.**

Note: In Local Plan areas other than those described below, PPO and Participating providers who contract with us will generally accept 100% of the Plan allowance as payment in full for covered services. As a result, you are only responsible for applicable coinsurance amounts, copayment amounts, amounts applied to the calendar year deductible, and any charges for noncovered services. **However, this may not apply when there is another source of payment besides you and us.** When you have other coverage (see Section 9), the following exceptions exist in our arrangements with PPO and Participating professional providers. Contact your Local Plan if you have questions about the amounts PPO and Participating providers may collect from you.

- In Arizona, when there is any other source of payment (whether we pay primary or secondary), PPO and Participating physicians are not obligated to accept our allowance as payment in full.
- In New York areas served by the Rochester Plan and in West Virginia, except when we pay secondary to other Blue Cross and Blue Shield coverage administered by the same Local Plan, PPO and Participating physicians may collect the difference between the total payments made by us and the primary carrier and the physician's charge.
- In Pennsylvania and Utah, when we pay secondary, PPO physicians are not obligated to accept our allowance as payment in full unless we make a payment as the secondary payer.
- In Puerto Rico, when we pay secondary, PPO physicians may collect the difference between the total payments made by us and the primary carrier and the physician's charge.
- In Montana, when we pay secondary, PPO and Participating physicians may collect the difference between the total payments made by us and the primary carrier and the physician's charge.
- In Rhode Island, South Carolina, and Vermont, except when we pay secondary to other Blue Cross and Blue Shield coverage, PPO and Participating physicians may collect the difference between the total payments made by us and the primary carrier and the physician's charge.

Patients' Bill of Rights

OPM requires that all FEHB Plans comply with the Patients' Bill of Rights, recommended by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. You may get information about us, our networks, and providers. You can also find out about care management, including medical practice guidelines, disease management programs, and how we determine if procedures are experimental or investigational. OPM's website (www.opm.gov/insure) lists the specific types of information that we must make available to you.

If you want more information about us, call or write to us. Our telephone number and address are shown on the back of your Service Benefit Plan ID card. You may also visit our website at www.fepblue.org.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you are covered or a family member is covered under another group health plan or has automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' guidelines. For example:

- If you are an annuitant under our Plan and also are actively employed, any group health insurance you have from your employer will pay primary and we will pay secondary.
- When you are entitled to the payment of health care expenses under automobile insurance, including no-fault insurance and other insurance that pays without regard to fault, your automobile insurance is the primary payer and we are the secondary payer.

When we are the primary payer, we will pay the benefits described in this brochure.

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance. For example, we will generally only make up the difference between the primary payer's benefits payment and 100% of the Plan allowance, subject to our applicable deductible and coinsurance or copayment amounts, except when Medicare is the primary payer (see Section 4). Thus, it is possible that the combined payments from both plans may not equal the entire amount billed by the provider.

Note: When we pay secondary to primary coverage you have from a prepaid plan (HMO), we base our benefits on your out-of-pocket liability under the prepaid plan (generally, the prepaid plan's copayments), subject to our deductible and coinsurance or copayment amounts.

In certain circumstances when we are secondary and there is no adverse effect on you (that is, you do not pay any more), we may also take advantage of any provider discount arrangements your primary plan may have and only make up the difference between the primary plan's payment and the amount the provider has agreed to accept as payment in full from the primary plan.

Remember: Even if you do not file a claim with your other plan, you must still tell us that you have double coverage, and you must also send us documents about your other coverage if we ask for them.

What is Medicare?

Medicare is a health insurance program for:

- People 65 years of age and older
- Some people with disabilities, under 65 years of age
- People with End Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant)

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A.
- Part B (Medical Insurance). Most people pay monthly for Part B.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare+Choice is the term used to describe the various health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on the type of Medicare+Choice plan you have.

- **The Original Medicare Plan**

The Original Medicare Plan is available everywhere in the United States. It is the way most people get their Medicare Part A and Part B benefits. You may go to any doctor, specialist, or hospital that accepts Medicare. Medicare pays its share and you pay your share. Some things are not covered under the Original Medicare Plan, such as most prescription drugs.

When you are enrolled in this Plan and the Original Medicare Plan, you still need to follow the rules in this brochure for us to cover your care. For example, you must continue to obtain prior approval for some prescription drugs and organ/tissue transplants before we will pay benefits. However, you do not have to precertify inpatient hospital stays when Medicare Part A is primary (see page 13 for exception).

Claims process – You probably will never have to file a claim form when you have both our Plan and Medicare.

- When we are the primary payer, we process the claim first.
- When the Original Medicare Plan is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will pay the balance of the covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call us at the number on the back of your Service Benefit Plan ID card or visit our web site at www.fepblue.org.

We waive some costs when you have Medicare: When Medicare is the primary payer, we will waive some out-of-pocket costs, as follows:

When Medicare Part A is primary, we will waive our:

- Inpatient hospital per-admission copayments;
- Inpatient Non-member hospital coinsurance; and
- Non-PPO inpatient per-day copayments for mental conditions/substance abuse care.

Note: Once you have exhausted your Medicare Part A benefits, we become primary. You must then pay any difference between our allowance and the billed amount at Non-member hospitals.

When Medicare Part B is primary, we will waive our:

- Calendar year deductible;
- Coinsurance for care by physicians and other health care professionals (inpatient and outpatient, including mental conditions/substance abuse care);
- PPO physician office visit copayments;
- PPO physician and facility copayments for routine physical examinations and preventive (screening) services; and

- Outpatient facility coinsurance for medical, surgical, preventive, and mental conditions/substance abuse care.

Note We do not waive benefit limitations, such as the 25-visit limit on occupational and speech therapy visits.

You must tell us about your or your covered family members' Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

The following chart illustrates whether the Original Medicare Plan or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly.

Primary Payer Chart

A. When either you – or your covered spouse – are age 65 or over and ...	**Then the primary payer is...**	
	Original Medicare	**This Plan**
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability)		
2) Are an annuitant		
3) Are a re-employed annuitant with the Federal government when...		
a) The position is excluded from FEHB, or.....		
b) The position is not excluded from FEHB.....		
Ask your employing office which of these applies to you.		
4) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge)		
5) Are enrolled in Part B only, regardless of your employment status	(for Part B services)	(for other services)
6) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty	(except for claims related to Workers' Compensation)	
B. When you - or a covered family member - have Medicare based on End Stage Renal Disease (ESRD) and...		
1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD		
2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD		
3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision		
C. When you - or a covered family member - have FEHB and...		
1) Are eligible for Medicare based on disability, and		
a) Are an annuitant, or.....		
b) Are an active employee.....		

- **Medicare managed care plan**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare managed care plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare managed care plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare managed care plans cover all Medicare Part A and Medicare Part B benefits. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare managed care plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov. If you enroll in a Medicare managed care plan, the following options are available to you:

This Plan and another Plan's Medicare managed care plan: You may enroll in another plan's Medicare managed care plan and also remain enrolled in our FEHB Plan. We will still provide benefits when your Medicare managed care plan is primary, even out of the managed care plan's network and/or service area, but we will not waive any of our copayments, coinsurance, or deductibles if you receive services from providers who do not participate in the Medicare managed care plan.

Suspended FEHB coverage and enrollment in a Medicare managed care plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage and enroll in a Medicare managed care plan, eliminating your FEHB premium (OPM does not contribute to your Medicare managed care plan premium). For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare managed care plan's service area.

- **Private contract**

A physician may ask you to sign a private contract agreeing that you can be billed directly for services ordinarily covered by the Original Medicare Plan. Should you sign an agreement, Medicare will not pay any portion of the charges, and we will not increase our payment. We will still limit our payment to the amount we would have paid after the Original Medicare Plan's payment.

- **Enrollment in Medicare Part B**

Note: We cannot require you to enroll in Medicare. If you choose not to enroll in Medicare Part B, you can still be covered under the FEHB Program.

TRICARE

TRICARE is the health care program for eligible dependents of military persons and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we pay first. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

Workers' Compensation

We do not cover services that:

- You need because of a workplace-related disease or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or a similar agency pays its maximum benefits for your treatment, we will cover your benefits.

Medicaid

When you have this Plan and Medicaid, we pay first.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, State, or Federal Government agency directly or indirectly pays for them.

When others are responsible for injuries

If another person or entity, through an act or omission, causes you to suffer an injury or illness, and if we pay benefits for that injury or illness, you must agree to the following:

- All recoveries you obtain (whether by lawsuit, settlement, or otherwise), no matter how described or designated, must be used to reimburse us in full for benefits we paid. Our share of any recovery extends only to the amount of benefits we have paid or will pay to you or, if applicable, to your heirs, administrators, successors, or assignees.
- We will not reduce our share of any recovery unless we agree in writing to a reduction, (1) because you do not receive the full amount of damages that you claimed or (2) because you had to pay attorneys' fees. This is our right of recovery.
- If you do not seek damages for your illness or injury, you must permit us to initiate recovery on your behalf (including the right to bring suit in your name). This is called subrogation.
- If we pursue a recovery of the benefits we have paid, you must cooperate in doing what is reasonably necessary to assist us. You must not take any action that may prejudice our rights to recover.

You must tell us promptly if you have a claim against another party for a condition that we have paid or may pay benefits for, and you must tell us about any recoveries you obtain, whether in or out of court. We may seek a lien on the proceeds of your claim in order to reimburse ourselves to the full amount of benefits we have paid or will pay.

We may request that you assign to us (1) your right to bring an action or (2) your right to the proceeds of a claim for your illness or injury. We may delay processing of your claims until you provide the assignment.

Note: We will pay the costs of any covered services you receive that are in excess of any recoveries made.

The following are examples of circumstances in which we may subrogate or assert a right of recovery:

- When you or your dependent are injured on premises owned by a third party; or
- When you or your dependent are injured and benefits are available to you or your dependent, under any law or under any type of insurance, including, but not limited to:
  - Personal injury protection benefits
  - Uninsured and underinsured motorist coverage (does not include no-fault automobile insurance)
  - Workers' compensation benefits
  - Medical reimbursement coverage

Contact us if you need more information about subrogation.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

----------x

EMPIRE HEALTHCHOICE ASSURANCE, INC. d/b/a EMPIRE BLUE CROSS BLUE SHIELD,

Plaintiff,

- against -

DENISE FINN McVEIGH, as Administratrix of the Estate of JOSEPH E. McVEIGH,

Defendant.

----------x

STATEMENT OF MATERIAL FACTS

CV # 03-CV-2728 (DC)

The defendant, DENISE FINN McVEIGH, as Administratrix of the Estate of JOSEPH E. McVEIGH, by her attorneys, hereby sets forth a Statement of Material Facts, pursuant to Local Civil Rule 56.1(a), as to which she contends there are no genuine issues to be tried.

1. Plaintiff seeks to recover the sum of $157,309.06 in health benefits it claims were paid on behalf of JOSEPH E. McVEIGH during his life as the result of medical treatment he received for injuries in an accident that occurred in 1997. The defendant relies on the allegations contained in plaintiff's Verified Complaint.

2. JOSEPH E. McVEIGH died on November 9, 2001 and DENISE FINN McVEIGH was appointed Administratrix of his Estate by the Surrogates' Court of New York County. Defendant will produce a

Certified Death Certificate and Letters of Administration issued by the Surrogates' Court of New York County.

3. Plaintiff alleges that it is entitled to recover the benefits alleged in paragraph "1" herein from the Estate of JOSEPH E. McVEIGH. Defendant relies on plaintiffs' Verified Complaint.

4. The administration of the Estate of JOSEPH E. McVEIGH is still pending. There have been no decrees or orders issued by the Surrogate of New York County relative to the approval or compromise of any wrongful death or personal injury claims or actions brought on behalf of JOSEPH E. McVEIGH, nor has any formal or informal accounting been issued or directed. Defendant will testify to the status of the Estate administration.

DATED: Mineola, New York
June 3, 2003

STOCK & CARR, ESQS.

by: VICTOR A. CARR (7542)

Attorneys for Defendant

88 Second Street
Mineola, New York 11501
(516) 747-2478

MERIDIAN RESOURCE CORPORATION

Page: 1

Medical Claim Itemization - Rolled Up

Sub Name: MCVEIGH, J
SSN: R51067314

Acc. Date: 5/19/1997
Case#: 271487

Our Client: Empire BlueCross BlueShield/FEP
Client #: 1-066-0000000001-0000

Family Total: $ 157,309.06

These claims have been paid for the patient JOSEP MCVEIGH as of: 02/28/2003

First Date of Service	Last Date of Service	Provider Name	Diag Code	Diagnosis	Charged	Paid	ICN
09/11/1997	09/11/1997	BOKSAY,	29480	ORGANIC BRAIN SYND NEC	$600.00	$27.79	80153492
10/06/1997	10/06/1997	BOKSAY,	29480	ORGANIC BRAIN SYND NEC	$900.00	$275.88	80063001
10/13/1997	10/17/1997	BOKSAY,	29480	ORGANIC BRAIN SYND NEC	$750.00	$360.00	80214430520
10/20/1997	10/20/1997	BOKSAY,	29480	ORGANIC BRAIN SYND NEC	$150.00	$45.98	73493239
02/18/1998	07/30/1998	BROWN	85400	NOS/INTRCRN HEM W/O WOUND/NOS CONSC	$34,200.00	$34,200.00	82323021
03/10/1998	04/30/1998	BROWN	85400	NOS/INTRCRN HEM W/O WOUND/NOS CONSC	$17,550.00	$17,550.00	81315128 ←
08/03/1998	08/31/1998	BROWN	85400	NOS/INTRCRN HEM W/O WOUND/NOS CONSC	$3,150.00	$3,150.00	82883014
10/01/1998	12/30/1998	BROWN	85400	NOS/INTRCRN HEM W/O WOUND/NOS CONSC	$32,850.00	$32,850.00	90256985
01/04/1999	01/14/1999	BROWN	85400	NOS/INTRCRN HEM W/O WOUND/NOS CONSC	$2,700.00	$2,700.00	90256986
01/19/1999	01/19/1999	BROWN,	85400	NOS/INTRCRN HEM W/O WOUND/NOS CONSC	$450.00	$98.40	90474449060
02/02/1999	02/09/1999	BROWN,	85400	NOS/INTRCRN HEM W/O WOUND/NOS CONSC	$2,250.00	$1,326.00	90474449070
02/10/1999	02/15/1999	BROWN,	85400	NOS/INTRCRN HEM W/O WOUND/NOS CONSC	$1,350.00	$885.60	90474449080
03/02/1999	03/09/1999	BROWN,,	85400	NOS/INTRCRN HEM W/O WOUND/NOS CONSC	$900.00	$590.40	90954420560
03/10/1998	04/30/1998	BROWNJAS	85400	NOS/INTRCRN HEM W/O WOUND/NOS CONSC	$17,550.00	$17,550.00	81313128 ←
03/10/1998	04/30/1998	BROWNJAS	85400	NOS/INTRCRN HEM W/O WOUND/NOS CONSC	$17,550.00	$17,550.00	82186995 ←
09/01/1998	09/14/1998	BROWNJAS	85400	NOS/INTRCRN HEM W/O WOUND/NOS CONSC	$2,700.00	$2,700.00	82723004
09/17/1998	09/29/1998	BROWNJAS	85400	NOS/INTRCRN HEM W/O WOUND/NOS CONSC	$2,700.00	$2,700.00	82853098
04/24/1998	04/24/1998	BURCHELL,	99850	POSTOPERATIVE INFECTION	$675.00	$205.20	81394409130
03/27/1998	04/14/1998	BURCHELL,,	87920	WOUND/ABDOMINAL WALL,ANTERIOR /SIMPLE	$330.00	$175.00	81254406960
02/14/1998	02/14/1998	COYNE,	78400	HEADACHE	$85.00	$55.00	80964411060
02/24/1998	02/24/1998	COYNE,	78900	ABDOMINAL PAIN,ACUTE OR SEVERE	$85.00	$55.00	80754410270
03/17/1998	03/17/1998	COYNE,	78900	ABDOMINAL PAIN,ACUTE OR SEVERE	$55.00	$40.00	80794411200
12/11/1997	12/11/1997	COYNE, JOHN A	78900	ABDOMINAL PAIN,ACUTE OR SEVERE	$85.00	$55.00	736504774
06/12/1997	06/17/1997	FERBER,	51882	OTHER PULMONARY INSUFFICIENCY, NEC	$1,410.00	$353.40	81694408470
09/16/1998	09/16/1998	GROSS,	71946	JOINT PAIN-LEG	$335.00	$202.00	82654428340
09/16/1998	09/16/1998	GROSS,	71946	JOINT PAIN-LEG	$588.00	$303.65	82804412040
12/20/1999	12/20/1999	KATZ,	46200	ACUTE PHARYNGITIS	$574.00	$214.70	93818031690
06/01/2000	06/01/2000	KATZ,	38918	SENSORNEUR LOSS COMB TYP	$168.69	$42.06	01548052110
10/15/1997	10/15/1997	LIANG, HOWARD G	87920	WOUND/ABDOMINAL WALL,ANTERIOR /SIMPLE	$150.00	$112.50	730803765
09/30/1997	10/20/1997	NYU HOSPITALS CENTER	30030	OBSESSIVE-COMPULSIVE DIS	$22,545.04	$14,464.00	80880022050
03/23/1998	03/23/1998	NYUMCFPO,	38910	SENSORNEUR HEAR LOSS NOS	$1,650.00	$1,087.50	80964403450
10/03/1997	10/08/1997	NYURADIO,	78400	HEADACHE	$341.50	$156.60	81184442510
10/10/1997	10/10/1997	PACIA,	78030	CONVULSIONS	$130.00	$123.50	73373281
01/06/1998	06/15/1998	ROSENBLU,	78039	OTHER CONVULSIONS	$450.00	$315.60	82014443140

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Medical Claim Itemization - Rolled Up

Sub Name: MCVEIGH, J
SSN: R51067314
Acc. Date: 5/19/1997
Case#: 271487
Our Client: Empire BlueCross BlueShield/FEP
Client #: 1-088-0000000001-0000
Family Total: $ 157,309.06

These claims have been paid for the patient JOSEP MCVEIGH as of: 02/28/2003

01/08/1998	01/08/1998	ROSENBLU,	43790	CEREBROVASC DISEASE NOS	$300.00	$159.00	80204414680
02/16/1998	02/16/1998	ROSENBLU,	43710	AC CEREBROVASC INSUF NOS	$75.00	$40.00	80784429100
07/20/1998	07/20/1998	ROSENBLU,	43790	CEREBROVASC DISEASE NOS	$75.00	$40.00	82124429100
10/19/1998	10/19/1998	ROSENBLU,	78030	CONVULSIONS	$75.00	$40.00	83104401600
10/27/1998	10/27/1998	ROSENBLU,	43790	CEREBROVASC DISEASE NOS	$300.00	$129.20	83454416270
10/27/1998	10/27/1998	ROSENBLU,	78039	OTHER CONVULSIONS	$300.00	$235.60	83104403260
02/03/1999	02/03/1999	ROSENBLU,	78039	OTHER CONVULSIONS	$75.00	$38.00	90424407040
02/25/1999	02/25/1999	ROSENBLU,	78039	OTHER CONVULSIONS	$300.00	$235.60	90634412810
03/10/1999	03/10/1999	ROSENBLU,	78039	OTHER CONVULSIONS	$75.00	$38.00	90774413310
05/20/1999	05/20/1999	ROSENBLU,	78039	OTHER CONVULSIONS	$300.00	$235.60	91674416150
06/07/1999	06/07/1999	ROSENBLU,	78400	HEADACHE	$75.00	$38.00	91824411090
07/12/1999	07/12/1999	ROSENBLU,	78039	OTHER CONVULSIONS	$75.00	$38.00	92024410050
09/13/1999	09/13/1999	ROSENBLU,	78039	OTHER CONVULSIONS	$75.00	$38.00	92654168130
04/24/1998	04/24/1998	ST. VINCENTS HOSPITAL AND	99883	NON-HEAL SURGICAL WOUND	$783.00	$975.00	81419248650
06/11/1997	06/11/1997	STONYBRO,,	95990	INJ/NOS	$2,185.00	$1,638.75	83084404110
					$172,983.23	$156,439.51	

MERIDIAN RESOURCE CORPORATION

Medical Claim Itemization - Rolled Up

Sub Name: MCVEIGH, J
SSN: R51067314

Acc. Date: 5/19/1997
Case#: 271487

Our Client: Empire BlueCross BlueShield/FEP
Client #: 1-088-0000000001-0000

Family Total: $ 157,309.06

These claims have been paid for the patient DENIS MCVEIGH as of: 02/28/2003

First Date of Service	Last Date of Service	Provider Name	Diag Code	Diagnosis	Charged	Paid	ICN
12/03/1998	12/03/1998	COYNE,	72450	BACKACHE,UNSPEC	$65.00	$55.00	83484413660
12/16/1998	12/16/1998	LIRADIOL,	72210	DISPLCMNT/LUMBAR DISC W/O MYELOPATHY	$1,250.00	$380.00	90084418850
12/15/1998	12/15/1998	SHEBAIRO,	72440	THORACIC/LUMBOSACRAL NEURITIS UNSPEC	$200.00	$190.00	90274404780
					$1,515.00	$625.00	

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MERIDIAN RESOURCE CORPORATION

Pags: 1

Medical Claim Itemization - Rolled Up

Sub Name: MCVEIGH, J
SSN: R51067314

Acc. Date: 5/19/1997
Case#: 271487

Our Client: Empire BlueCross BlueShield/FEP
Client #: 1-088-0000000001-0000

Family Total: $ 157,309.06

These claims have been paid for the patient JOSEPH MCVEIGH as of: 02/28/2003

First Date of Service	Last Date of Service	Provider Name	Diag Code	Diagnosis	Charged	Paid	ICN
01/01/1900	01/01/1900		85400	NOS/INTRCRN HEM W/O WOUND/NOS CONSC	$103.48	$37.05	730004016
01/01/1900	01/01/1900		85400	NOS/INTRCRN HEM W/O WOUND/NOS CONSC	$150.00	$112.50	729602607
01/01/1900	01/01/1900	COYNE, JOHN A	85090	CONCUSSION/NOS	$125.00	$95.00	726605074
					$378.48	$244.55	